2018

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

Amended August 14, 2017

Washington Health Benefit Exchange
810 Jefferson Street SE
Olympia, Washington 98501

Section 1: Introduction

This Guidance for Participation specifies requirements for a health insurance issuer to participate in the Washington State Health Benefit Exchange (WAHBE or the Exchange). An issuer may participate in the individual Exchange by offering qualified health plans (QHPs) from November 1, 2017 through January 15, 2018, for coverage in plan year 2018. An issuer may also offer QHPs through the Small Business Health Options Program (SHOP) that covers small-employer groups in Washington State. A separate section in this document provides guidance to issuers wanting to participate in SHOP.

The Guidance will provide information on the following:

- Certifying a health plan to become a QHP
- Monitoring and compliance of a QHP
- Decertifying a QHP
- Standards for carriers offering QHPs through the Exchange
- Expectations for carrier coordination with the Exchange
- Special guidance for coverage of American Indian/Alaska Natives

This Guidance is in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA authorized the creation of state-based marketplaces, also known as exchanges. The Washington State Legislature established WAHBE by adding a new chapter to Title 43 RCW, 43.71 RCW. WAHBE is governed by an eleven-member Board consisting of nine voting Board members and two non-voting, ex-officio members, the Washington State Insurance Commissioner and the Director of the Washington State Health Care Authority. The WAHBE Board is authorized by the Legislature to certify QHPs offered through HPF using 19 certification criteria.

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

1.1 Glossary

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

ACTUARIAL VALUE

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

AFFORDABLE CARE ACT

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

APPEAL

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

ENROLL

The point at which coverage is effective under a QHP.

ENROLLEE

Qualified individual or qualified employee enrolled in a QHP.

EXPIRE

The end of a plan year in which a QHP issuer elects not to seek recertification of a QHP offered through the Exchange for the following year. This act by the QHP 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 health insurance company; “product” refers to a suite of plans that share, for example, a common set of health benefits; and “health plan” refers to the actual insurance coverage purchased by a consumer. The document does not refer to health insurance companies as the “plans” or “the health plans.”)

HEALTH PLAN

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

NAVIGATOR

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

OPEN ENROLLMENT PERIOD

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

The open enrollment period for 2018 coverage is from November 1, 2017 through January 15, 2018. The federal open enrollment period of November 1 – December 15, 2017 is being extended through January 15, 2018 in Washington through a special enrollment period, under flexibility given to state-based exchanges in federal regulations (Patient Protection and Affordable Care Act; Market Stabilization; https://federalregister.gov/d/2017-07712).

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

PLAN YEAR

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

PRODUCER

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

QUALIFIED DENTAL PLAN OR QDP

A stand-alone dental plan that is certified by an Exchange 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 284-43-5700) under specific cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

QUALIFIED HEALTH PLAN OR QHP

A health plan that is certified by an exchange. To be certified in Washington, a health plan must be approved by OIC, satisfy the certification criteria specified in RCW 43.71.065, and satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156.

QUALIFIED HEALTH PLAN ISSUER OR QHP ISSUER

A health insurance issuer that provides coverage through a qualified health plan offered through the Washington Health Benefit Exchange.

SHOP

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

SPECIAL ENROLLMENT PERIOD

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

WASHINGTON HEALTHPLANFINDER OR HEALTHPLANFINDER

The marketplace in Washington State operated by the Washington Health Benefit Exchange where qualified individuals and small employers can shop for and purchase qualified health plans (QHPs) and qualified dental plans (QDPs).

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide health insurance issuers the foundational information needed to offer individual and/or SHOP QHPs through the Exchange. The certification criteria set forth within this document do not supersede a QHP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some federal and state laws or regulations that apply to offering health insurance coverage through the Exchange, this document does not release a QHP issuer from complying with all relevant state and federal laws. Please see Appendix 1 for a directory of federal rules issued under the ACA.

The Guidance also specifies the certification criteria that apply to a participating health plan. To be certified a QHP must:

- Be approved by OIC;
- Satisfy the certification criteria specified in RCW 43.71.065; and
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156.

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

1.2.2 Term of Engagement

An individual or SHOP health insurance plan certified or recertified as a QHP will be offered through the Exchange. New and renewed individual plans will be available beginning November 1, 2017 with an initial effective date of coverage beginning no earlier than January 1, 2018. The date when SHOP plans will be made available for plan year 2018 will be announced in a separate communication with coverage beginning no earlier than January 1, 2018.

Health insurance issuers responding to this Guidance may offer certified or recertified individual QHPs for a term of one year beginning January 1, 2018 and ending December 31, 2018, or small group QHPs for term of one year with the plan year beginning in 2018. Only OIC-approved health plans certified by the Board may be offered as QHPs through the Exchange during this period.

The Guidance shall be amended as required to incorporate changes to federal and state law.

1.2.3 Contact

Your contact at WAHBE for this document is Christine Gibert, Associate Policy Director. Please direct all questions regarding plan certification and this document to Christine Gibert at (360) 688-7773 or QHP@WAHBExchange.org.

1.2.4 Plan Certification Timeline and Letter of Intent

An issuer is recommended to inform WAHBE of its intent to participate in the Exchange. Submitting a letter of intent is not mandatory and is nonbinding, but will help WAHBE prepare for the certification process and the open enrollment period. WAHBE does not request that an issuer indicate the specific health plans it intends to offer through the Exchange. WAHBE requests issuers submit the market(s)

(individual and/or SHOP) in which they intend to offer QHPs. WAHBE also requests that issuers include a list of counties in which they intend to offer coverage. An issuer may submit a letter of intent at QHP@WAHBExchange.org.

PLAN CERTIFICATION TIMELINE

Please click on the following link to find the most recent plan certification timeline:

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

1.3 Participating in the Exchange

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

1.3.1 Initial Certification of Qualified Health Plans

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

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

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

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

Issuers who rely primarily on third-party vendors for communication of enrollment data are expected to coordinate with WAHBE when there is a change in vendors.

1.3.2 Recertification of Qualified Health Plans

WAHBE will consider renewing QHPs for recertification annually. The recertification process will involve a review of the certification criteria reflected in this document.

1.3.3 Submitting Health Plans to Become Certified as a QHP

The WAHBE certification process begins when an issuer submits a rate and form filing to OIC for regulatory review and approval of a health plan to be offered in the Exchange. Please refer to OIC for information on how and where to submit the rate and form filing for a health plan. WAHBE intends to complete the certification or recertification process for 2018 plans by September 14, 2017. The Exchange reserves the right to charge an issuer for incurred costs if a plan is withdrawn after the certification process is completed.

Section 2: Specifications for Participation

2.1 Summary Table 1: Initial Certification and Recertification Criteria

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

NUMBER	CRITERIA LEVEL	CRITERIA	OIC OR WAHBE REVIEW	INITIAL CERTIFICATION CRITERIA	RECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes	Yes
3	Issuer	Issuer must comply with the risk management programs	OIC	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accredited by an entity that HHS recognizes for accreditation of health plans	WAHBE	Yes	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes	Yes
8	Product	QHP must meet network access requirements, including ECPs	OIC	Yes	Yes
9	Product	Issuer must submit provider directory data	WAHBE	Yes	Yes
10	Product	Issuer must implement a quality improvement strategy	WAHBE	Yes	Yes
11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	WAHBE	Yes	Yes

12	Product	Issuer must report quality and health performance data	WAHBE	Yes	Yes
13	Product	Issuer must use the Exchange enrollment application	WAHBE	Yes	Yes
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Services provided under a QHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply with benefit design standards (e.g. cost sharing limits, “metal level”, EHB)	OIC	Yes	Yes
17	Plan	Issuer must submit a QHP’s service area and rates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	No	Yes
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	WAHBE	Yes	Yes

2.2 QHP Specifications

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

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 QHP through the Exchange.

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

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

2.2.2 User Fee Adherence

RCW 43.71.060 designates a portion of premium tax receipts and a fee assessed on QHPs as funding for WAHBE's operating expenses.

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

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

2.2.3 Risk Adjustment Program

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

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

2.2.4 Market Rules for Offering QHPs

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

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

Only a QHP issuer that satisfies the following market rules may offer QHPs through the Exchange:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level.
- An issuer must offer a child-only plan at the same level of coverage as any QHP (which does not include catastrophic plans) offered through the Exchange (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.
- If OIC determines that a QHP issuer is not complying with the market rules, and OIC further determines that the QHP issuer will not resume compliance with the market rules, then WAHBE will decertify all of the issuer's QHPs in that market.

2.2.5 Non-Discrimination

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

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

2.2.6 Accreditation

The QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. WAHBE will verify an issuer’s accreditation status for certification or recertification.

A QHP issuer must achieve AAAHC, NCQA, or URAC exchange accreditation at least 90 days before the first day of the annual open enrollment period that follows the QHP issuer’s fourth certification process. QHP issuers must maintain current accreditation every subsequent year of participation and provide proof of ongoing accreditation at least 90 days prior to the annual open enrollment period. The issuer must present a copy of each accreditation certificate (one per accredited product type (e.g., HMO, PPO)) to the Exchange.

A QHP issuer shall notify the Exchange of any accreditation review scheduled for the upcoming plan year. The issuer shall notify WAHBE within ten business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation.

WAHBE reserves the right to decertify a QHP if accreditation is terminated or not achieved by the relevant deadline.

WAHBE will certify a health plan as accredited if one of the following statuses is held by the QHP issuer:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim status requires a second review within 18 months)
    - WAHBE will not recognize NCQA status: denied
- URAC: full, provisional, or conditional (conditional status requires a second review within three to six months)
    - WAHBE will not recognize URAC status: denial
- AAAHC: Certificate of Accreditation
    - WAHBE will not recognize AAAHC status: denial

WAHBE may certify a QHP prior to that health plan becoming Exchange-accredited as described below. During a new issuer's initial and next two certification processes, WAHBE may certify a health plan as a QHP that is unaccredited if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "Exchange accreditation" (in accordance with 45 CFR §§156.275 and 156.1045) in the product types (HMO, EPO, MCO, POS, or PPO) used in offering its QHPs.
- A QHP issuer must achieve Exchange accreditation and provide proof of that accreditation at least 90 days before the first day of the annual enrollment period that follows the QHP issuer's fourth certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2015 plan year, it would need to achieve and document Exchange accreditation by the beginning of the certification process to be performed by WAHBE during 2017 for offering QHP coverage in the 2018 plan year.

2.2.7 Marketing

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

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

QHP issuers will be expected to confirm the accuracy of the display of their marketing and enrollment materials during carrier ratification (the validation of plan data in *Washington Healthplanfinder*). Marketing materials will not be displayed on *Washington Healthplanfinder* if they do not conform to the standards set through this criterion.

2.2.8 Network Access

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

- Is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-170-200, et. seq., and any subsequent federal or state rules.

OIC will enforce network access requirements and monitor for noncompliance. If OIC determines that a QHP issuer is not complying with the network access requirements, and OIC determines that the QHP issuer will not resume compliance with the network access requirements, WAHBE will decertify all of the issuer's QHPs affected by that noncompliance. Please refer to OIC for additional regulatory guidance on network access.

2.2.9 Provider Directory

QHP issuers must provide data on the health care providers that participate in networks associated with their QHPs sold on the Exchange. QHP issuers are required to update their provider directory data with the Exchange, and any vendor utilized by the Exchange to support the provider directory, by the 15th of each month, unless otherwise instructed.

For the provider directory data that is to be used for the start of open enrollment, issuers must include providers for the current and upcoming plan years. For the duration of the 2017 plan year, providers for both the 2017 and 2018 plan years will be included in the issuer data submissions. Issuers will identify the appropriate plan year(s) associated with each provider. At the conclusion of the 2017 plan year, providers that are not associated with issuer networks for 2018 should be removed from the submission.

On-time submissions are processed and published to *Washington Healthplanfinder* on the first day of the following month. A QHP issuer must ensure that the network name for each provider exactly matches the network name as approved by OIC.

2.2.10 Quality Improvement Strategy

Any eligible QHP issuer participating in the Exchange for three or more consecutive years must implement, and report on, a quality improvement strategy (QIS), in accordance with ACA § 1311(g), other applicable law, and Exchange guidance. A QIS is required to incentivize quality by tying payments to (1) performance measures when providers meet specific quality indicators, or (2) measures related to incentivizing enrollees to make certain choices or exhibit behaviors associated with improved health.

An eligible issuer for the 2018 plan year is any QHP issuer that:

- Offered coverage through the Exchange in 2015, 2016, and 2017,
- Provides family and/or adult-only medical coverage, and
- Meets the QIS minimum enrollment threshold (more than 500 enrollees within a product type as of July 1, 2016).

The QIS requirements apply to all issuers offering QHPs and Multi-State Plan (MSP) options in the individual and SHOP markets that meet the above criteria. For plan year 2018, QIS requirements will not apply to child-only plans or stand-alone dental plans. Pursuant to recently released federal guidance, for the first time in 2018, QIS requirements will apply to QHPs that are compatible with health savings accounts (HSAs).

All eligible issuers must comply with the following QIS requirements for the 2018 plan year:

- Implement a QIS, which is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- Implement a QIS that includes at least one of the following:
  - Activities for improving health outcomes;
  - Activities to prevent hospital readmissions;
  - Activities to improve patient safety and reduce medical errors;
  - Activities for wellness and health promotion; and
  - Activities to reduce health and health care disparities.
- Adhere to federal guidelines, including the QIS Technical Guidance and User Guide for the 2018 Coverage Year.
- Report on progress implementing the QIS to the Exchange in accordance with guidelines established by the Exchange.

Issuers may implement one QIS that applies to all eligible QHPs in the Exchange, or may implement more than one QIS, tailored to the needs of different QHPs. A QIS does not have to address the needs of all enrollees in a given QHP, but may address needs of specified sub-populations.

Eligible issuers for the 2018 plan year must submit the following documents to WAHBE in order to meet this certification criterion:

- A QIS applicable to any QHP to be offered in the Exchange in the form and manner specified by the Exchange, which for the 2018 plan year will require use of the QIS Implementation Plan and Progress Report Form provided by WAHBE
- A one- to two-page summary of each QIS applicable to a QHP to be offered on the Exchange that will be viewable on the Exchange corporate website.

Because 2018 will be the second year of implementation of the QIS, issuers who submitted a QIS for 2017 must both submit their 2018 QIS as well as report on the status of their 2017 QIS during the 2017 plan year, per federal guidance.

Eligible issuers who submitted a QIS for the 2017 plan year will need to indicate that they are submitting a new QIS for 2018 if any of the following changes are made to their 2017 QIS:

- QIS market-based incentive type or sub-type change;
- Change or addition of QIS topic area;
- One or more of the QIS performance targets are reached or changed; or
- The QIS results in negative outcomes or unintended consequences.

If an issuer with a 2017 QIS did not make any of the above changes, it should indicate that it is submitting a continuing QIS, with or without modifications, as appropriate.

Under CMS regulation, for the 2018 plan year, issuers with a 2017 QIS are required to complete a Progress Report as part of their 2018 QIS submission. This Progress Report is Section F of the QIS Implementation Plan Form, and should include data about the 2017 QIS implemented to comply with these QIS requirements for the 2017 plan year.

Issuers are required to submit their QIS and the QIS summary in both PDF and Word Formats, and include the issuer's logo. The QIS summary will be viewable by consumers on the Exchange corporate website. The due date for issuers to submit their QIS and the QIS summary to the Exchange will be announced in a separate communication.

2.2.11 Standard Format for Presenting Health Benefit Plan Options

Issuers are required to provide WAHBE with a Summary of Benefits and Coverage (SBC) for each plan variant of a QHP, in English and Spanish, for display on *Washington Healthplanfinder*. Issuers will need to use the standard SBC form developed by the Department of Health and Human Services (HHS). For the 2018 plan year, issuers will use the new SBC required by CMS and expected to be issued in April 2017. Issuers will be required to provide an SBC for each plan either through a PDF or a direct link to the issuer's website. More information on the required vehicle for display of the SBC is forthcoming.

A standard SBC form, developed by HHS, may be found here:
https://www.cms.gov/cciio/Resourceslforms- reports-and-other-resources/index.html

Issuers will submit SBCs to the Exchange via email or other similar means. One compressed/zip folder will contain all variations of the plan. The name of the folder will be the HIOS Plan ID. Each SBC file will be named as follows:

- Full Plan Name
- English or Spanish
- Cost Share Tier (01,02,03,04,05)

Sample:

- Zip Folder: 12345WA0020001
    - File Name: ExcellentCare1BronzeEnglish01
    - File Name: ExcellentCare1BronzeSpanish01

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

Issuers will include direct links to a plan's drug formulary in each SBC that must be accessible to consumers. A direct link is a link that does not require logging on to a website, entering a policy number, clicking through web pages, or creating user accounts, memberships, or registrations. This link must directly take a client to a webpage that displays the formulary for the benefit package reflected on the SBC. A direct link is not a link to a search tool or webpage that requires additional navigation by the client to get to the formulary.

All SBCs are required to include underlined terms that are included in CMS's Uniform Glossary. The new SBC expected to be released by CMS during 2017 allows (but does not require) issuers to fully hyperlink underlined terms used in the Uniform Glossary, which directs consumers to the term's definition when they click on the term. The Exchange encourages issuers to hyperlink all underlined terms included in CMS's Uniform Glossary.

2.2.12 Quality Measures

To satisfy this criterion, QHP issuers are required to participate in the federal Quality Rating System (QRS) provided under ACA Section 1311(c)(3), including the disclosure and reporting of information on health care quality and outcomes described in ACA Sections 1311(c)(1)(H) and 1311(c)(1)(I), and the implementation of appropriate enrollee satisfaction surveys consistent with ACA Section 1311(c)(4) (and 45 CFR §156.200(b)(5)). Issuers must also comply with additional federal guidance regarding the QRS and enrollee satisfaction surveys, including requirements described in the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guide for 2017 and the 2017 Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

All qualifying issuers offering a QHP of any metal level through the Exchange must comply with QRS requirements and report on all quality measures defined by CMS. For data reporting to CMS during 2017 (to be displayed during the open enrollment period for the 2018 plan year), a qualifying issuer is an issuer that offers a product type in the Exchange that meets the minimum enrollment threshold (more than 500 enrollees in that product type as of both July 1, 2016 and January 1, 2017). An issuer that meets the minimum enrollment threshold but is offering a different product type for 2018 coverage will have the option of displaying their QRS rating for plans of the different product type.

CMS will work with issuers to collect data and calculate the quality performance ratings for QHPs offered through the Exchange. During the open enrollment period for the 2018 plan year, the Exchange will display QHP quality rating information. During 2017, qualifying issuers will report data from the 2016 plan year to CMS, and that data will be analyzed by CMS and be the basis for the quality performance ratings to be displayed in the Exchange during Open Enrollment for 2018 coverage.

For the 2018 plan year, the Exchange expects to display the overall plan rating and three summary indicator ratings for each eligible QHP. In future years, additional quality ratings may be displayed.

In addition to the requirements described above, a QHP issuer will also be required to participate in any other quality reporting requirements that may be authorized by federal regulation or specified by WAHBE.

2.2.13 Exchange Enrollment Application

The electronic enrollment application process within *Washington Healthplanfinder* is the single streamlined application for determination of eligibility and enrollment in Washington State as required under 45 CFR §155.405 and satisfies this criterion for QHP Issuers.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital meets certain patient safety standards, including use of a patient safety evaluation system and a comprehensive hospital discharge program. These contractual requirements are monitored by OIC. A QHP issuer must provide the CMS Certification Number (CCN) to the Exchange upon request for each hospital subject to these requirements with which it is contracted.

2.2.15 Direct Primary Care Medical Homes

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

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

2.2.16 Benefit Design Standards

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

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

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

2.2.17 Services Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, or health status related factors specified under section 2705(a) of the Public Health Service Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). A QHP service area will be generally defined by county or counties; however, an issuer demonstrating good cause, as specified in WAC 284-43-0160(29), may request that OIC approve a QHP service area defined by zip codes. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable. Consumers will be able to identify a service area by providing a zip code and county in *Washington Healthplanfinder*.

Please refer to OIC for further regulatory guidance on service area requirements.

WAHBE will display the rates on the *Washington Healthplanfinder* web pages. A QHP issuer's health plan rates are for an entire benefit or plan year. Approval of a plan by OIC will confirm that a QHP has met the service area and rating requirements.

2.2.18 Posting Justifications for Premium Increases

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

2.2.19 Reporting Data

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

WAHBE will use these templates to populate *Washington Healthplanfinder* with rates, benefits, service area, and provider network names. WAHBE will not alter the data within these templates without written direction from OIC. Issuers are required to review this data during the annual ratification process (the validation of plan data in *Washington Healthplanfinder*) to ensure the accuracy of the information.

Issuers offering QHPs through the Exchange must 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, including the grace period report required under RCW 48.43.039.
- Estimation or collection of assessments or fees specified in RCW 43.71.080.

WAHBE will make enrollment data available to QHP issuers to support issuers in complying with this certification criterion.

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

2.3 Pediatric Dental Essential Health Benefit

RCW 43.71.065 specifies that *Washington Healthplanfinder* will offer stand-alone dental plans, required under Section 1311(d)(2) of the ACA to include the pediatric dental essential health benefit (described in ACA Section 1302). Washington law further specifies that dental benefits must be offered and priced separately to assure transparency for consumers through *Washington Healthplanfinder*. Stand-alone dental plans will not be offered in SHOP in 2018. Instead, pediatric dental benefits are embedded in SHOP QHPs. Please refer to OIC for further guidance on setting the rate for stand-alone dental plans. A separate Guidance for Participation for Qualified Dental Plans offered through *Washington Healthplanfinder* can be found on the WAHBE website.

2.4 Monitoring and Compliance of Qualified Health Plans

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

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

NUMBER	CRITERIA LEVEL	CRITERIA	MONITORING ENTITY	WAHBE PENALTY	DECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	N/A	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes (see Section 2.2)	Yes
3	Issuer	Issuer must comply with the risk management programs	OIC	N/A	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	N/A	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	N/A	Yes
6	Issuer	Issuer must be accredited by an entity that HHS recognizes for accreditation of health plans within specified timeframe	WAHBE	No	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes (see Section 2.2.7)	No
8	Product	QHP must meet network access requirements, including ECPs	OIC	N/A	Yes
9	Product	Issuer must submit provider directory data	WAHBE	No	No
10	Product	Issuer must implement a quality improvement strategy	WAHBE	No	No
11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	WAHBE	No	No

12	Product	Issuer must report quality and health performance measures	WAHBE	No	No
13	Product	Issuer must use the Exchange enrollment application	WAHBE	No	No
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	N/A	Yes
15	Product	Services provided under a QHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	N/A	Yes
16	Plan	A QHP must comply with benefit design standards (e.g. cost sharing limits, "metal level," EHB)	OIC	N/A	Yes
17	Plan	Issuer must submit a QHP's service area and rates for a plan year	OIC	N/A	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	N/A	No
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	WAHBE	No	No

2.5 QHP Status Changes

2.5.1 Changes to Plans as Part of the Annual Certification Process

WAHBE certification of a QHP lasts for one plan year and must be renewed each future plan year in which the QHP seeks to be offered in the Exchange, as set forth in 45 CFR §156.290 and 45 CFR §155.1080. During the annual plan filing and certification process, a QHP issuer may elect not to seek Exchange recertification of a QHP and may discontinue the plan at the end of the year. A QHP issuer must notify WAHBE of any QHPs for which it intends to seek certification or recertification upon filing the plan with OIC. An issuer must fulfill the obligations set forth in 45 CFR §156.290 with respect to any QHP that will be discontinued at the end of a plan year, including providing coverage until the end of the plan year and providing the required 90-day discontinuation notice to enrollees. During the Exchange's automated renewal process in open enrollment, the Exchange will cross-map enrollees in discontinued plans to another plan of the same issuer, if available, in accordance with 45 CFR §155.335 and other applicable regulations. If an enrollee's plan is discontinued and no other plan of the same issuer is available, the Exchange may cross-map the enrollee to an available plan of a different issuer in accordance with 45 CFR 155.335 and other applicable regulation.

An issuer may discontinue all coverage in an individual or small group market and exit that market entirely. A QHP issuer must provide written notice to WAHBE that all of the issuer's QHPs in a market (individual or small group) will be discontinued at least 180 days before the date the coverage will expire. The QHP issuer must also provide formal 180-day notice to enrollees as required in RCW 48.43.035 for SHOP QHPs and in RCW 48.43.038 for individual market QHPs. The QHP issuer must terminate coverage for the enrollees, as set forth in 45 CFR §156.270, only after the enrollees have had an opportunity to participate in open enrollment as set forth in 45 CFR §156.290.

2.5.2 Denial of Recertification

A renewed plan that is approved by OIC may be denied certification as a QHP by WAHBE if the plan does not meet the certification criteria described in this Guidance for Participation. If a QHP is denied recertification by WAHBE, the QHP will not be offered through the Exchange for the next plan year and the issuer must fulfill the obligations set forth in 45 CFR §156.290, which include providing coverage until the end of the plan year.

2.5.3 Changes to Plans After Certification

WAHBE reserves the right to recoup from an issuer costs incurred by the Exchange resulting from the withdrawal of a plan from being offered in the Exchange after the QHP certification process is completed.

2.5.4 Changes to Plans During a Plan Year

Decertification of a QHP could occur in the middle of a plan year if OIC withdraws regulatory approval or if WAHBE determines that a QHP no longer satisfies certification criteria. WAHBE will decertify QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080. QHP issuers must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after the Exchange has notified enrollees and the enrollees have had an opportunity to participate in special or open enrollment as outlined in 45 CFR §155.1080. If the plan is decertified by WAHBE but maintains OIC regulatory approval, the QHP shall be made available outside of *Washington Healthplanfinder* for any current enrollees. A QHP issuer may never again offer a decertified QHP through *Washington Healthplanfinder*, except as required by state or federal law or deemed necessary by WAHBE.

If a QHP issuer petitions OIC to suspend new sales for the individual or small group market, the QHP issuer must notify WAHBE of OIC petition and subsequent OIC action on the petition for suspension within five business days of OIC's decision. The QHP issuer must enroll any new enrollees "in the pipeline" with effective dates after the date of closure. WAHBE will no longer offer a suspended QHP during open enrollment. A suspended QHP must continue to provide special enrollment to its current enrollees with qualifying events but will not participate in special enrollment when enrollees of other QHPs or new enrollees experience qualifying events. To be offered through *Washington Healthplanfinder*, a suspended QHP must continue to achieve annual recertification.

Section 3: Special Guidance for Coverage for American Indian/Alaska Natives (AI/AN)

An issuer must comply with all federally required laws and regulations specific to AI/AN individuals in the ACA and other federal regulations, including but not limited to:

- A once-a-month enrollment period to enroll or change plans in *Washington Healthplanfinder* for any AI/AN individual enrolled in a federally recognized tribe or Canadian Indian lawfully present in the US under the Jay Treaty;
- No cost sharing for AI/AN QHP enrollees with incomes under 300% of federal poverty level who are otherwise eligible for tax credits through the Exchange;
- No cost sharing for AI/AN QHP enrollees for any item or service furnished through Indian Health Care Providers or through referral under contract health services as defined in Section 1402(d)(2) of 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 Care Providers in their service area. If an issuer contracts with an Indian Health Care Provider, the issuer will notify WAHBE in a timely fashion of this relationship.

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

A QHP issuer must adhere to sponsorship program requirements as referenced in Section 6.1 below, including accepting payments from and issuing refunds to Exchange-registered tribal sponsors.

Section 4: SHOP Specifications

WAHBE operates the Small Business Health Options Program (SHOP) in Washington. WAHBE will certify QHPs to be offered through SHOP and determine employer eligibility, support employee open enrollment and special enrollment periods, and perform premium aggregation through the billing and collection of employer premium payments. To be offered through SHOP, a plan must be submitted as both an employee only and an employee plus dependent(s) plan. SHOP plans may be offered to employers with at least one common law employee and no more than 50 full-time equivalent employees as defined by the ACA and federal rules.

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

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

Based on federal requirements, the SHOP must:

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

Section 5: Issuer Certification Appeal Process

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

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

An issuer's appeal must:

- Identify the specific criterion or criteria appealed;
- Provide information that clarifies the issuer's position on each unsatisfactory criterion; and
- Succinctly state the outcome sought by the issuer.

After submitting the appeal:

- WAHBE will send written notice to the issuer within seven calendar days from the date that the appeal was received.
- The issuer will have the opportunity to address the Board about the appeal prior to a Board decision regarding the appeal.
- The Board will have up to 20 calendar days from receipt of the appeal to send a final written decision that upholds or denies the issuer's appeal.

The Board's written response to such an appeal will be a final decision and all appeals with respect to that health plan will be exhausted. This appeal process represents the sole remedy for an issuer with respect to a Board decision regarding initial certification of a health plan or recertification or decertification of a QHP offered through *Washington Healthplanfinder*.

Section 6: Enrollment in a QHP

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.

A QHP issuer must agree to comply with WAHBE standards and processes established for the individual and/or SHOP market for transfer of enrollment and effectuation files, reconciliation, and reporting. This includes accepting all required forms of payment, managing grace periods, and adhering to sponsorship program requirements established in RCW 43.71.030 and the WAHBE Sponsorship Policy available on the WAHBE website (e.g., accepting payments on behalf of individuals from Exchange-registered sponsors; issuing refunds to Exchange-registered sponsors; providing a sponsor with an accounting of the total amount owed to the issuer). If a QHP issuer performs verification of special enrollment events, it does so on behalf of the Exchange for the purpose of requirements under RCW 43.71.035.

6.1.1 Plan Mapping

WAHBE utilizes plan mapping in the individual market in order to facilitate renewals during the annual open enrollment period and help consumers avoid breaks in coverage. Plan mapping may be applied in circumstances in which an issuer discontinues a particular plan or product for the following year. Plan mapping may also be utilized in circumstances in which two or more existing products are combined into one renewal plan for the following year. WAHBE may utilize plan mapping across issuers to enroll individuals who no longer have an Exchange plan available to them from the same issuer. These individuals will be cross-mapped into a similar plan from a different issuer for the following year.

All issuers that offer QHP coverage through the Exchange during 2017 and 2018 must perform mapping for plan year 2018 in accordance with applicable state law and federal requirements. Issuers must generally cross-map all prior year non-renewing QHPs to another QHP available in the same county for the subsequent year. WAHBE will review each carrier's cross-mapping assignments for compliance with applicable law, including federal requirements set forth in 45 CFR 155.335, state law, and OIC guidance. WAHBE may cross-map enrollees from one issuer to another, as permitted by applicable law and according to OIC guidance.

Issuers must use WAHBE's Plan Mapping Submission Form to provide plan mapping information; WAHBE will not accept the CMS Plan Crosswalk Template.

6.1.2 File Transfer and Payment Due Dates

For 2018 enrollments, QHP issuers are expected to comply with the following due dates for initial payments and effectuation, cancellation, and termination files:

<u>Effectuation during Open Enrollment</u>

- 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.

- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.
- An effectuation or cancellation transaction is due to the Exchange within 10 business days of binder payment due date.

Effectuation during Special Enrollment

If issuer does not verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th 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 being effectuated under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date the issuer receives the enrollment transaction.

If issuer does verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the date of verification.
- For coverage being effectuated under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date of verification.

Rescission due to failure to prove special enrollment qualifying event:

- During special enrollment, issuers may rescind an enrollee's coverage if the documentation provided to an issuer does not support the qualifying event. Cancellations of coverage due to failure to provide documentation to support the qualifying event shall be communicated to the Exchange via the manual reconciliation process (i.e., issuers will not transmit an 834 transaction).
- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

Termination for Nonpayment

Termination for nonpayment transaction is due to Exchange within 15 business days of expiration of one month (non-APTC) or three month (APTC) grace period.

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 (45 CFR §147.106). If the enrollee does not pay all outstanding premiums by the end of the three-consecutive-month grace period, the carrier must terminate the enrollment retroactively to the last day

of the first month of the grace period. If the 2018 coverage resulted from auto-renewal of the 2017 coverage, the 2018 coverage should also be cancelled as never effective. (See 45 CFR §156.270 and §155.430.) Where the enrollee actively completes plan selection for 2018, termination retroactively ends the prior year's coverage, leaving the new benefit year's coverage in place. This new benefit year is subject to its own grace period.

Changing from Termination for Nonpayment to Voluntary Termination

If an issuer receives a payment after an enrollee is terminated for nonpayment, the issuer should change the reason for termination to voluntary termination. This change must be communicated to the Exchange via the reconciliation process within 15 days of the payment being processed. These changes impact 1095-As sent to members and IRS reporting.

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

6.2 Producer and Navigator Specifications

6.2.1 Producer

Producers who are authorized to sell *Washington Healthplanfinder* products will be able to present QHP offerings to individuals and small businesses in Washington State. To become a registered producer with WAHBE, a producer must hold a valid Washington State disability producer license, sign the WAHBE User Participation Agreement, and attend a certification or recertification class annually.

Please refer to OIC for more information on producer licensing requirements

6.2.2 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 *Washington 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.

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), https://www.cms.gov/CCIIO/Resources/Regulations- and-Guidance/index.html