



washington
healthplanfinder

click. compare. covered.

Carrier Enrollment & Payment Process Guide Individual Market

April 2018

Version 6.0

TABLE OF CONTENTS

1	<i>Introduction</i>	3
1.1	Affordable Care Act	3
1.2	Washington Health Benefit Exchange	3
1.3	Document Purpose	3
1.4	Revision History	3
1.5	Amendments to Document	4
1.6	Relationship to 834 Companion Guide	4
1.7	Compliance with State and Federal Laws	4
1.8	HBE Contact Information	4
2	<i>Acronyms and Descriptions</i>	5
3	<i>Washington Healthplanfinder and the Individual Market</i>	7
3.1	Eligibility	7
3.2	Medicare	7
3.3	Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSRs)	8
3.4	Form 1095-A Health Insurance Marketplace Statement	8
3.5	Exemptions to the Shared Responsibility Payment	8
3.6	Appeals	9
4	<i>Washington Healthplanfinder System of Record</i>	10
4.1	Enrollment Transactions	10
4.2	Change Reporting Requirement	11
4.3	Individual Member Demographics	12
4.4	Enrollment Data	12
5	<i>Payments and Effectuations</i>	16
5.1	Premium Payment Methods	16
5.2	Premium Payment Due Dates	16
5.3	Effectuations	17
5.4	Cancellations for Non-Payment	17
5.5	Terminations for Non-Payment	18
5.6	Grace Periods and Delinquency Process	18
	Non-Subsidized (non-APTC)	18
	Subsidized (APTC).....	18
5.7	Changing Non-Payment Terminations to Voluntary Terminations	18
6	<i>Open Enrollment and Renewals</i>	18
6.1	Renewals – Open Enrollment	18
	Auto Renewal Batch	19
	Manual Renewal	19
6.2	New Enrollments –Open Enrollment	22
 Special Enrollment Periods	
	23
7		23
7.1	Availability	23
7.2	Special Enrollment Qualifying Life Event	24

7.3	Verification of Special Enrollment Qualifying Events.....	24
	SEP Verification Process.....	24
	Special Enrollment 834 Codes.....	24
	Carrier Termination or Cancellation of Coverage if Qualifying Life Event Not Approved.....	24
	Special Enrollment Qualifying Life Events.....	25
	Special Enrollment Correspondence.....	29
	Changing from Family to Dependent Coverage or Dependent to Family Coverage.....	29
8	Enrollment Terminations and Reinstatements	31
8.1	HBE-Initiated Terminations.....	31
8.2	Applicant-Initiated Terminations	32
8.3	Applicant-Initiated Cancellations	32
8.4	Carrier-Initiated Terminations	33
8.5	Reinstatements.....	33
9	Reconciliation of Enrollment Data	34
9.1	Daily Exceptions	35
9.2	Weekly Error Resolution.....	35
9.2.1	Enrollment Analyst and Carrier 1:1 Meetings.....	35
9.2.2	HBE and Carrier 1:1 Meetings.....	35
9.2.3	HBE All-Carrier Meeting.....	36
9.3	Monthly Audit Reconciliation Process.....	36
9.3.1	Audit Discrepancy Types.....	36
9.3.2	Monthly Audit Process Flow.....	36
9.3.3	Audit File Generation Timeline.....	37
9.3.4	Audit File Contents.....	37
9.4	Monthly Audit Discrepancy Categories.....	37
9.5	Urgent Discrepancies.....	39
9.6	Payment Reporting During Open Enrollment.....	39
9.7	40	
9.8	Enrollment Discrepancies	40
10	Appendix A: Carrier Generated Audit File Scenarios	41
10.1	Assumptions	41
10.2	Scenarios	41
10.3	SEP Scenarios.....	44

1 INTRODUCTION

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

1.1 AFFORDABLE CARE ACT

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

The ACA creates competitive private health insurance marketplaces that provide millions of Americans and small businesses access to affordable healthcare coverage. SBEs help individuals 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 (HBE).¹

1.3 DOCUMENT PURPOSE

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

- Qualified Health Plan (QHP) issuers and Qualified Dental Plan (QDP) issuers (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
3/9/2018	6.0 – Draft	Version of document updated to 6.0 to align with Open Enrollment and <i>Healthplanfinder</i> Releases. Revised draft to include Open Enrollment Payment process, Exemption Letter process, and updated SEP events and codes.
7/17/2017	5.0 – Draft	Entire Document Revision. Version of document updated to 5.0 to align with Open Enrollment and <i>Healthplanfinder</i> Releases
2/10/2017	3.0.1 – Draft	Updated
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”

¹ RCW 43.71.020

8/17/2016	3.0 – Draft	Entire document reorganized and revised
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. 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. HBE will formally publish the guide on the HBE website each year on August 1st, or the next following business day.

Once the final version of the guide is published, any clarifications or updates to the guide will be issued via supplemental bulletins or minor versions of the guide (e.g., 3.0.1) to coincide with point releases. HBE will formally publish supplemental bulletins or minor versions of the guide 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 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.

1.7 COMPLIANCE WITH STATE AND FEDERAL LAWS

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

1.8 HBE CONTACT INFORMATION

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

2 ACRONYMS AND DESCRIPTIONS

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

ACRONYM/TERM	DESCRIPTION
FTI	Federal Tax Information
HBE	Washington Health Benefit Exchange
Healthplanfinder or Washington Healthplanfinder	Washington Health Benefit Exchange's consumer facing online marketplace
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Federal Data Services Hub
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 Options Program
WAH	Washington Apple Health
WAHBE	Washington Health Benefit Exchange

3 WASHINGTON HEALTHPLANFINDER AND THE INDIVIDUAL MARKET

3.1 ELIGIBILITY

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

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

Applicants determined conditionally eligible will be included in enrollment transactions transmitted to carriers. HBE does not report conditional eligibility status to carriers, but the status may result in enrollment changes or terminations at the end of the 95-day period. Coverage will not retroactively terminate for individuals determined ineligible at the end of the 95-day period. Rather, enrollment changes or termination dates will follow monthly enrollment deadlines.

Healthplanfinder does not permit applicants to apply Advanced Premium Tax Credit (APTC) to QDPs and cost-sharing reductions are not applicable to QDPs under federal law.

3.2 MEDICARE

Section 1882(d) of the Social Security Act prohibits the sale or issuance of an individual health insurance policy that duplicates a Medicare beneficiary's benefits. Healthplanfinder will deny eligibility for QHP/QDP enrollment when an applicant indicates they have Medicare.

Carriers must communicate to HBE via the reconciliation process instances when dual Medicare and QHP enrollment is known for HBE to contact the applicant. CMS guidance prohibits carriers from terminating enrollees whom they subsequently find to be eligible for or enrolled in Medicare, unless the enrollee requests the termination.² Existing applicants enrolled in QHPs that become eligible for or enroll in Medicare after they have already enrolled in QHP coverage may maintain their coverage but are no longer eligible for APTC or CSRs. Once notified of a dually enrolled applicant, HBE will contact the applicant and explain options to the applicant: 1) remain enrolled in QHP without APTC/CSR; or 2) disenroll from the QHP.

Consistent with regulations governing guaranteed renewability of coverage, Medicare eligibility or enrollment is not a basis to not renew an individual's health insurance coverage in the individual market under the same policy or contract of insurance.³ HBE is currently developing processes to better identify applicants entitled to or enrolled in Medicare prior to processing renewing coverage each year.

² 45 CFR §147.106

³ 45 CFR §147.106

3.3 ADVANCED PREMIUM TAX CREDIT (APTC) AND COST SHARING REDUCTIONS (CSRs)

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

Consumers with incomes between 100% and 400% of the federal poverty level (FPL) may be eligible for APTC.⁴ Individuals and families between 100% and 250% of the FPL are also eligible for CSRs if they enroll in a silver plan.⁵ HBE will report the applied APTC and CSR eligibility to the carrier and Centers for Medicare & Medicaid Services (CMS) to facilitate payment from CMS to the carrier.

3.4 FORM 1095-A HEALTH INSURANCE MARKETPLACE STATEMENT

HBE generates the Form 1095 as the covered individual's record for Exchange QHP and QDP coverage. Consumers use Form 1095-A to complete Form 8962 Premium Tax Credit, and reconcile advance payments of the premium tax credit or claim the premium tax credit on the individual annual tax filing.

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

Corrections: For instances when an applicant believes their 1095-A document is incorrect, they can request a correction review via HBE's 1095 webpage: <https://www.wahbexchange.org/current-customers/your-1095-a-statement/>

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

3.5 EXEMPTIONS TO THE SHARED RESPONSIBILITY PAYMENT

The ACA requires most individuals to have health insurance (individual mandate) or pay a penalty (shared responsibility payment). Applicants who want to request an exemption from this penalty must make their request with either the Internal Revenue Service (IRS) or the Federal Marketplace. Applicants *should not* upload an exemption request through *Washington Healthplanfinder* or send their exemption request to HBE or Customer Support Staff.

To apply for an exemption, applicants 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.

⁴ Non-citizens who are lawfully present and who are ineligible for Medicaid due to immigration status may be eligible for APTC if their income is less than 100% of the FPL.

⁵ 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.

Find exemptions that may work for you

Select the button below. We'll ask you a few questions and show you all health coverage exemptions that may apply to you.

FIND EXEMPTIONS**Exemption Letter Process**

The Affordable Care Act requires that all individuals have health coverage and those that do not have qualifying coverage are subject to a penalty during tax filing. Individuals that experience certain circumstances can seek exemptions from the penalty for not having coverage.

HBE does not grant exemptions, but may provide letters of support for individuals that wish to seek hardship exemptions from HHS because they were without qualifying coverage for some period during the year due to an error caused by the Exchange.

- The consumer will contact the Exchange and request an exemption letter due to a gap in coverage resulting from an error of the Exchange.
- If failure on the part of the Exchange is determined to be the reason for the consumer's gap in coverage, a hardship Exemption letter will be drafted by HBE and reviewed by the Exemption Review Team for final approval.
 - Failure on the part of the Exchange does not include failure on the part of the carrier to process the 834 transaction, including changes to the enrollment after the initial add
- Failure on the part of the Exchange does not include failure on the part of the carrier to invoice the customer, resulting in termination or cancellation for non-payment. If failure on the part of the carrier is determined to be the reason for the consumer's gap in coverage, the consumer will be directed to obtain a hardship exemption request letter from the carrier.

3.6 APPEALS

Any consumer who applies through *Washington 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 *Washington Healthplanfinder*
- Whether the consumer can enroll in a *Washington Healthplanfinder* plan outside the regular open enrollment period
- 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
- The HBE Board policy requiring all children to enroll in a dental plan through *Healthplanfinder*
- Billing disputes and refund requests
- The carrier's decision to deny a special enrollment period
- Claims the insurance company denied to pay

4 WASHINGTON HEALTHPLANFINDER SYSTEM OF RECORD

Washington Healthplanfinder is the system of record for all eligibility, enrollment, premium amounts, and demographic information. Any changes in demographic information must be reported directly to the *Washington Healthplanfinder*. HBE utilizes the individual and enrollment record to generate enrollment transactions to carriers, report premium tax credits and CSRs to CMS, and generate the annual 1095-A tax form for applicants.

Changes that must be reported through *Washington 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
Applicant-Initiated Voluntary Disenrollment

Carriers should refer the applicant to www.wahealthplanfinder.org to update their individual account or call the Washington Healthplanfinder Customer Support Center at 1-855-WAFINDER (1-822-923-4633).

4.1 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 HBE and carriers offering products through HBE. The 834 Companion Guide addresses the 834 EDI requirements for the Individual Market.

Data Fix Indicator:

HBE will include a data fix indicator for all transactions resulting in a manual review by HBE. Transactions with this indicator have been manually reviewed by HBE and should be con.

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 HBE to the carrier. An 834 Add is sent by 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 HBE in response to receipt of an 834 Add from HBE.
834 Change	The 834 Change is sent from HBE to the carrier 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 APTC and/or CSR, when there is a change in third party sponsorship status, when there is a change to broker information, change of address, and for other reasons.
834 Cancel (HBE Initiated)	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 HBE when the subscriber fails to make the required binder payment prior to the carrier's premium payment due date.
834 Term (HBE Initiated)	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 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)	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.

4.2 CHANGE REPORTING REQUIREMENT

All applicants are required to report changes that may impact their eligibility for QHP enrollment. Applicants who have requested to be considered for affordability programs are required to report changes that may impact program eligibility.⁶ This change reporting obligation may result in potential churn between Medicaid eligibility and subsidized or non-subsidized QHP coverage. HBE will support reenrollment of QHP/QDP coverage during the annual open enrollment period or upon eligibility for a special enrollment period (SEP).⁷

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

⁶ 45 CFR §155.330 (b)

⁷ 45 CFR §155.420 (d)

4.3 INDIVIDUAL MEMBER DEMOGRAPHICS

The *Washington Healthplanfinder* application captures individual member demographics such as address, first name, last name, date of birth, SSN, and gender. Applicants must be referred to *Washington Healthplanfinder* to update their demographic information.

Location

In order to comply with regulations related to access to Medicaid programs, the first two lines of the physical address are not required fields in *Washington Healthplanfinder* for a consumer applying for QHP/QDP coverage. Carriers are expected to process EDI transactions missing the first two lines of a physical address. HBE will follow the 834 Add with an 834 Change after outreach is conducted and a physical address is obtained.

All EDI transactions missing the first two lines of the physical address are stopped by HBE and manually reviewed. The HBE Enrollment Analyst will perform outreach to these consumers to update the physical address fields in their *Healthplanfinder* account. After updating the address, the initial add transaction missing the first two lines of the physical address will be sent to carriers. A change transaction communicating the address update will follow the add transaction. The carrier may request that HBE update a physical address via the reconciliation process.

American Indian/Alaska Native indicator

Eligibility for the American Indian/Alaska Native (AI/AN) coverage provisions is included in 834 transactions for the subscriber and/or dependent 2100 loop DMG line. Carriers are expected to comply with all laws and regulations specific to AI/AN individuals 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 or change plans
- \$0 cost sharing for AI/AN consumers with incomes under 300% of the FPL, so long as the AI/AN consumer is APTC eligible
- \$0 cost sharing for item or service furnished through Indian Health Care Providers (regardless of income or receipt of APTC)
- 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
- Compliance with Indian Health Care Improvement Act Sections 206 and 408

4.4 ENROLLMENT DATA

Washington Healthplanfinder is the system of record for enrollment data. This includes policy and member-level start and end dates, premium information, APTC, and CSRs.

Multiple Enrollments

Healthplanfinder allows multiple enrollments for a single household. Applicants are allowed to create separate enrollments among individuals in the same household. Carriers should process multiple enrollments with the same Subscriber and/or dependent IDs sent in separate 834 transactions.

Multiple Enrollments Example 1: Primary applicant and their dependent choose to enroll in separate coverage during open enrollment. The Primary applicant selects a Bronze plan for themselves and

selects a Gold plan for their dependent. HBE will generate an 834 Add transaction file with coverage code FAM for the first enrollment and second 834 Add transaction file with coverage code DEP.

Multiple Enrollments Example 2: Primary applicant is not seeking coverage, spouse is enrolled in DEP coverage effective January 1. On May 13 a birth is reported and the applicant chooses to enroll the new enrollee in separate coverage. HBE will generate an 834 Add with coverage code DEP with a distinct Enrollment ID from the existing enrollment.

Coverage Start Dates: Enrollment coverage start and end dates are communicated via 834 transactions. In general, coverage effective dates are based on an applicant's plan selection date. A plan selected from the 1st through the 15th of a month is effective the 1st of the following month. Plans selected from the 16th through 31st (or last day) of a month are effective the 1st of the second following month. Certain SEP events (e.g. birth) allow or require an earlier or later start date based on the date of event rather than the plan selected date.

Coverage End Dates: Coverage end dates are communicated via 834. HBE will send outbound 834 terms for cancellations, voluntary terminations, death, and eligibility denials.

Carrier requests to move coverage start or end dates: When carriers approve changes to enrollees' coverage start or end dates, carriers shall work directly with the Enrollment Analyst for processing. The following information must be included in the request sent to HBE:

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

Premium: *Washington Healthplanfinder* is the system of record for premium amounts. Premiums are rated individually. The premium calculated at the time of plan selection is based on the rating factors effective as of the coverage effective date. These factors include:

- **Location:** The physical address entered during the application process is used to determine the rating area used to calculate the premium rating. The applicant is required to designate a zip code for purposes of area rating in instances when no physical address is provided. The applicant is required to make a county designation for an address location at the boundary of two rating areas.
- **Plan:** The current year CMS Plan ID rates are used to calculate the premium rating.
- **Age:** The age at the time of the coverage effective date is used to calculate the premium rating.
- **Tobacco** (if applicable): The application designation of tobacco use at the time of plan selection is used to calculate premium rating.

Impact of change reporting on premiums: Changes reported by the 15th monthly cutoff and before the coverage start date that impact the rating factors for a previously rated enrollment will be taken into account for re-rating and will apply to the upcoming enrollment for the duration of the enrollment. Changes to rating factors reported after the 15th cutoff or during the effective coverage period will not impact the premium rating for the duration of the coverage, as long as the enrollee remains covered under the same plan.

Premium example 1: Primary Applicant selects a plan during the open enrollment period on November 5 for a January 1 start date. On December 8, the applicant updates the application tobacco designation from No to Yes. **The applicant is re-rated using their latest tobacco factor due to change reported prior to the monthly 15th cutoff.**

Premium example 2: Primary Applicant selects a plan during the open enrollment period on November 5 for a January 1 start date. On December 26, the applicant updates the application tobacco designation from No to Yes. **The applicant is not re-rated using their latest tobacco factor due to change reported after the monthly 15th cutoff.**

Enrollment changes: For mid-year changes to rating factors, rerating for currently enrolled applicants will not occur while remaining continuously enrolled in the same CMS Plan ID.

- FAM to DEP/DEP to FAM (Change in Enrollment ID)
- Member-level Add/Term (Change in enrollment composition)

HBE will re-rate existing enrollees based on the latest rating factors for:

- **Cross-calendar enrollments:** Applicants are rated based on the latest factors for plans effective in a new calendar year
- **Plan change as a result of an SEP:** Applicants are rated based on the latest factors when they change plans (identified by the 14 digit CMS plan ID) mid-year, whether they stay with the same or switch to a new carrier.

Premium Example 3: Applicant enrolls in Plan A during the open enrollment period for a plan to start January 1. April 21 is an applicant's date of birth. On July 5, the applicant reports a change resulting in an SEP. Same day they enroll in Plan B (with a different 14-digit CMS plan ID) with the same carrier for an August 1 start date. **The applicant is re-rated using their latest rating factors, including their increased age, due to the plan change.**

- **Gap in coverage:** Applicants are rated based on the latest factors when a mid-year gap in coverage of at least 1 day occurs.

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

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

Premium Example 5: On March 9, the applicant applies for coverage due to birth, date of the event: February 2. The same day they enroll into a QHP/QDP product with a February 2 start date. February 20 is the applicant's birthday; they turned 35. **The applicant is rated using the rating factors as of March 9 except for age due to the retroactive start date that crosses a date of birth. They are rated with the March 9 factors for location and tobacco, but re-rated to age 34 for age.**

- **Change in location with same CMS Plan ID:** Applicants are rated based on their age and location at the time of the plan effective date. Applicants who report a change in location mid-year and whose coverage is available in their new location will retain the original age rating but be rated for their new location following the 15th cutoff.

Premium Example 6: 35 year old Primary Applicant enrolled in coverage in King county. On September 8th, the applicant reports a permanent move to Snohomish county. Their existing QHP is available in their new rating area. The applicant reconfirms their existing plan selection. **The applicant is rated using their original coverage start date, but their rating can change due to the location update.**

Mid-month effective dates and premium pro-rating: Pro-rating adjustments to the monthly premium will be calculated and invoiced by the carrier. Carriers will be responsible for pro-rating premiums in the event of mid-month enrollment and disenrollment. 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.

APTC amounts: Individuals and families determined eligible for APTC will only receive the tax credit if they enroll in a QHP through HBE. The APTC can be applied to Gold, Silver and Bronze QHP plans. Catastrophic plan enrollments are not eligible for APTC. *Healthplanfinder* does not permit APTC to be applied to QDP plan premiums.

HBE notifies applicants of the maximum APTC amount for which they are eligible during the shopping experience prior to selecting a health insurance plan. The applicant can apply the maximum APTC amount for which they are eligible or apply less monthly to receive the remaining credit with their annual tax filing. The tax credit they choose to apply to their premium (the APTC) cannot exceed cost of the essential health benefit (EHB) portion of the plan premium. HBE will report the APTC amount to the carrier and CMS to facilitate the payment from CMS directly to the carrier.

Cost-sharing reduction tier: There are 6 cost-sharing reduction tiers. One tier designates no cost-sharing reductions. There are three Silver metal level CSR tiers and two CSR tiers specific to AI/AN enrollees.

Tier 1 – Not eligible for cost sharing reductions

This tier is the default tier for all plans, unless the conditions are met for eligibility into another tier

Tier 2 – Zero Cost-Sharing: American Indian/Alaska Native tier

Tier 3 – Limited Cost-Sharing: American Indian/Alaska Native tier

Tier 4 – 73% AV Variant: Silver plan tier

Tier 5 – 87% AV Variant: Silver plan tier

Tier 6 – 94% AV Variant: Silver plan tier

Broker: If applicable, HBE will communicate via 834 transaction file the broker of record. Reconciliation of broker issues is addressed via an HBE Reconciliations Analyst.

Third-Party Payer (Sponsor): HBE will communicate via 834 transaction file when the applicant is partnered with an HBE Sponsor. Reconciliation of sponsorship issues is addressed by contacting an HBE Enrollment Analyst.

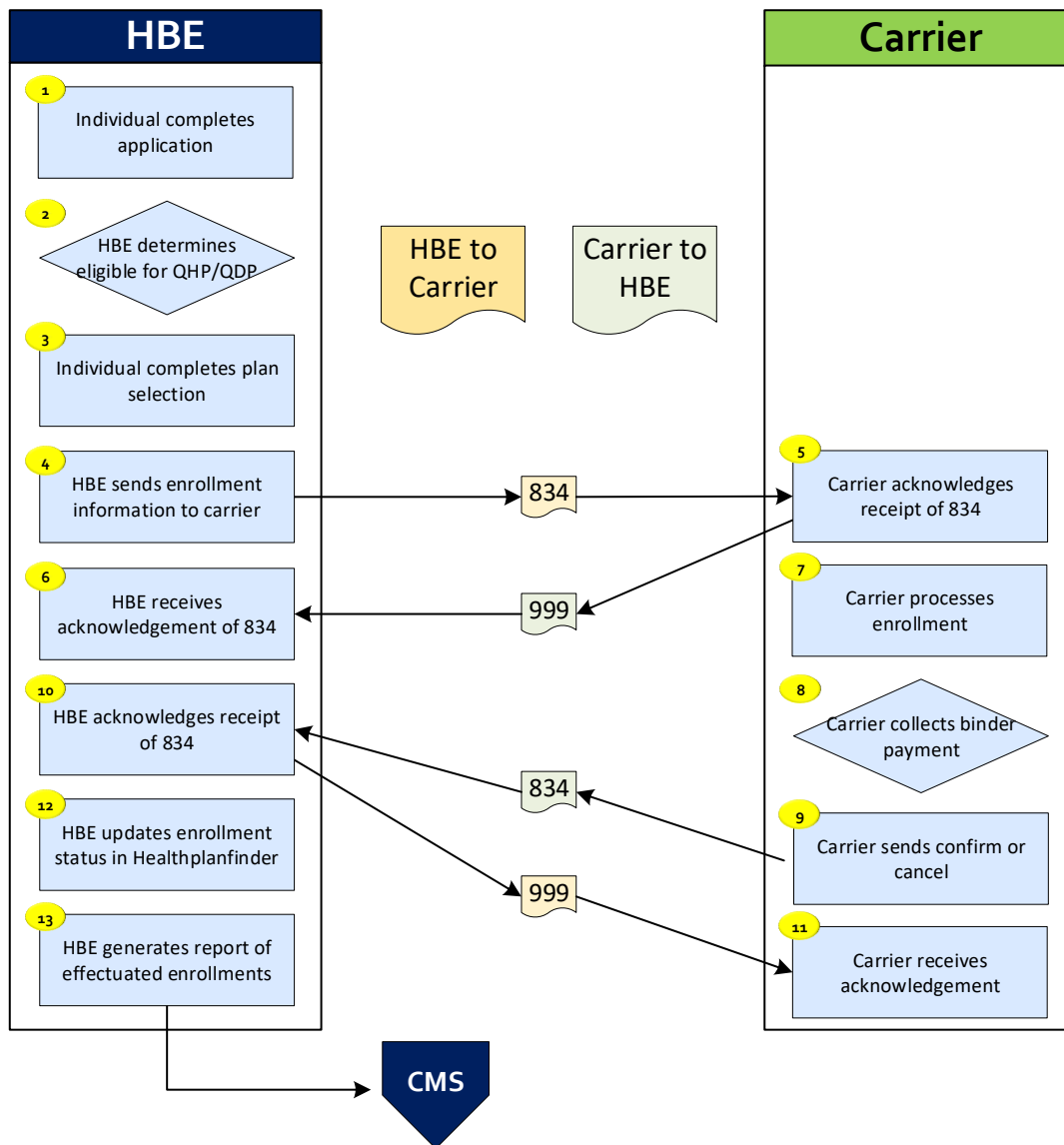
5 PAYMENTS AND EFFECTUATIONS

5.1 PREMIUM PAYMENT METHODS

Federal regulations require carriers to accept paper checks, cashier's checks, money orders, electronic funds transfer (EFT), and all general-purpose pre-paid debit cards⁸.

5.2 CARRIER PAYMENT AND EFFECTUATION PROCESS

Payment and Effectuation Process



⁸ 45 CFR 156.1240

5.3 BINDER PAYMENTS

New enrollments initiated during OE or by SEP require a binder payment to become effectuated.⁹ Renewals into a new product or new carrier also require a binder payment to become effectuated.

Length and Duration: The 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. 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. The due date must allow at least 15 business days from the time the applicant receives the invoice to make the binder payment.

Carrier Enrollment Response: Carriers must send HBE a response to effectuate within 10 business days of receipt of a binder payment. Carriers must send HBE a response to cancel within 10 business days of the binder payment due date.

5.4 REGULARLY-BILLED PAYMENT

Once a binder payment is received and the enrollment effectuated, the enrollee begins the regularly-billed monthly payment cycle. A grace period is initiated when a premium has not been paid by the monthly due date.

Length and Duration: The grace period begins on the 1st day of the month after the first missed payment. Carriers must allow a one-month grace period for non-subsidized enrollments and a three-month grace period for all enrollments with any amount of APTC applied monthly.

To eliminate the length of a grace period changing during the middle of the grace period, as this would be confusing to enrollees and result in otherwise avoidable non-payment terminations, carriers shall permit the applicants in an existing three-month grace period to complete the remaining portion of the grace period.¹⁰

There are two scenarios where this may occur:

1. Loss of APTC: Enrollees that become past due and enter the subsidized grace period, and who lose their eligibility for APTC for any reason during the grace period, are able to complete the remaining portion of the grace period as though the loss of eligibility for APTC did not occur.
2. Continuous coverage during renewals: The 2017 Notice explains § 156.270(d) was amended to eliminate language limiting the three-month grace period for enrollees receiving APTC to only those enrollees who made a payment during the benefit year. Consistent with guaranteed renewability of coverage, carriers must accept the renewal of the enrollee since the enrollee is still in a grace period. These enrollments are treated the same as a regularly-billed monthly premium payment. Carriers may continue to bill auto renewals via their existing billing cycle and a binder payment of the first month's premium is not required. A missed January payment will initiate the appropriate grace period based on the prior year's paid through date. In instances when the end of the grace period is December 31st, the carrier can choose to effectuate or reject the enrollment. The policy must be applied equally to all applicants.

Lapsed grace periods: Carriers may terminate enrollments if payment is not received to bring the account current before the end of their grace period. This scenario is discussed in Section 8.4 Carrier-Initiated Terminations

⁹ 45 CFR 155.400 (d)

¹⁰ 2017 Benefit and Payment Parameters Rule

5.5 PAST DUE PAYMENTS

Carriers may attribute to past due premiums owed by the applicant for a prior coverage term with the same carrier, or to an issuer in the same controlled group, payments made for new coverage; and condition effectuation of that new coverage on the payment of past due premiums owed to that carrier for coverage in the prior 12-month period. Past due premiums refers to premiums that have not been paid by the applicable due date. It does not include premiums for months in which individuals were not enrolled in coverage. Generally an applicant will not owe more than three months of their net subsidy premium to effectuate new coverage.

Look-back period: 12-month period preceding effective date of new coverage.

Notice to applicants: Carriers adopting the look-back policy must describe in any enrollment application materials, and in any notice regarding nonpayment of premiums, consequences of non-payment on future enrollment.

Responsible Party Limitation: Carriers may only condition the effectuation of new coverage on payment of past due premiums for the individual contractually responsible for the past-due premium.

5.6 CHANGING NON-PAYMENT TERMINATIONS TO VOLUNTARY TERMINATIONS

HBE maintains the system of record for enrollment via *Washington Healthplanfinder*. Voluntary terminations of coverage will occur via *Washington Healthplanfinder* 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 9: Reconciliation). HBE will update the *Washington 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 Enrollment 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.

6 OPEN ENROLLMENT AND RENEWALS

6.1 RENEWALS – OPEN ENROLLMENT

HBE aims to reenroll all current enrollees for the upcoming plan year.

AUTO RENEWAL BATCH

Auto renewal is the process HBE uses to reenroll current enrollees to ensure cross-calendar year continuous coverage. Enrollees will be auto renewed into a similar plan when the original plan is no longer available. Enrollees will be auto renewed into a similar plan with a new carrier when the original carrier no longer services the area (“cross-mapped enrollment”). Reenrollment into a same plan or mapped to a different plan in the same product is considered a renewal for purposes of binder payment and grace period requirements.

An enrollee will be auto renewed if the following criteria are met:

1. Eligible for auto renewal: A small number of applicants are determined ineligible for auto renewal and are notified by HBE to take action during the open enrollment period to complete renewal.
2. Active QHP and/or QDP enrollment as of the start of the open enrollment period: Previous QHP enrollees with a terminated enrollment at the time of the batch will not be included in the auto renewal batch.

Some enrollees opt to not provide consent for HBE to obtain and utilize Federal Tax Information (FTI) during the annual auto renewal process. Subsidized applicants are auto renewed as unsubsidized if all other criteria are met. This does not impact the current year enrollment. The enrollee can complete a manual renewal after the batch and re-apply for subsidized eligibility.

Auto Renewal EDI Generation:

A separate batch is run following the auto renewal batch to generate the EDI transactions to auto renew enrollees for the upcoming plan year. The batch initiates termination transactions for the current year enrollment and creates new enrollment records for the upcoming plan year. A new Enrollment ID is issued for the upcoming year enrollment.

For the 2019 plan year, auto renewal EDI transactions will generate on **November 1, 2018**. This means that carriers may receive cancellation or change transactions impacting enrollment and invoicing (e.g. premium amount if new members are added or change in APTC amount if income is updated) between 11/1 and 12/15 (i.e., enrollment cutoff for January 1 coverage start date). For this reason, HBE recommends that carriers wait to invoice enrollees until the first week of December. Receiving the bulk of EDI transactions earlier during open enrollment will allow a carrier more time to process EDIs and generate invoices for the majority of its membership.

MANUAL RENEWAL

Enrollees not included or successfully enrolled in the auto renewal batch can complete a manual renewal during the open enrollment period. Enrollees included in the batch also have an opportunity to report household eligibility changes to be effective in the upcoming and current plan year and to change plans for the upcoming year. Manual renewals completed between November 1 through November 15 will impact December coverage when any changes reported result in a change in program eligibility. Manual renewals occurring between November 16 and December 15 take effect January 1. Changes reported during this period may also result in an SEP.

Special Enrollment Periods during manual renewals: Applicants may also become eligible for an SEP during manual renewals. Manual renewals can also result in 834 Add, 834 Change, or 834 Term or Cancel transactions

for the current and upcoming plan years. Certain SEP events include a retroactive effective date and will result in SEP codes being included in transactions for next year’s coverage even though the changes are reported during open enrollment and applied to the enrollment for the current and/or upcoming plan year. This is because *Healthfinder* is a single streamlined application for both current and next year’s coverage.

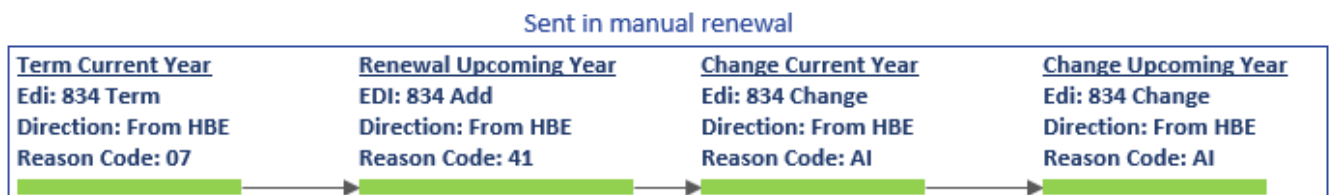
Note: These scenarios will include multiple files for the same subscriber ID. The carrier will have to rely on the 834 timestamp.

Scenario 1: The enrollee is auto renewed for the 2018 plan year. The applicant remains enrolled in the same product with the same carrier but subsequently reports changes that impact his eligibility for APTC and CSRs for the current and upcoming plan year.

The applicant was included in Auto Renewal batch:

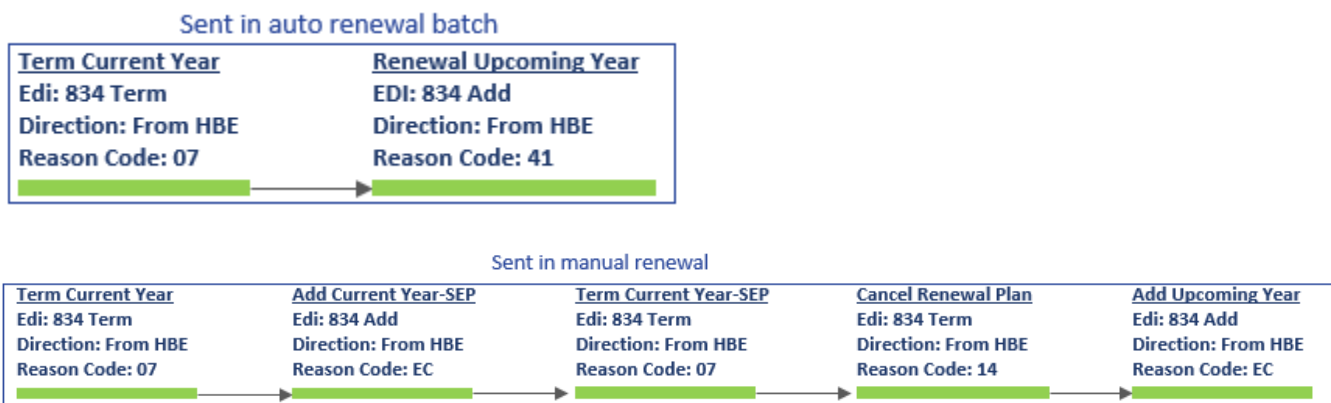


The applicant was not included in Auto Renewal batch:



Scenario 2: The applicant completes a manual renewal and reports changes that impact both current and upcoming year enrollments. The applicant enrolls into a new product with the same carrier for both the current and upcoming plan years.

The applicant was included in Auto Renewal batch:



The applicant was not included in Auto Renewal batch:

Sent in manual renewal



Scenario 3: The applicant completes a manual renewal and reports changes that impact both current and upcoming year enrollments. The applicant enrolls into a new product with a new carrier for both the current and upcoming year.

The applicant was included in Auto Renewal batch:

Sent in auto renewal batch



Sent in manual renewal



Not included in Auto Renewal:

Sent in manual renewal

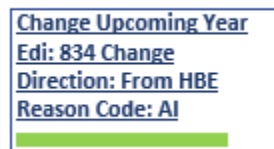


Scenario 4: The applicant completes a manual renewal that impacts only the upcoming plan year enrollment. The applicant remains enrolled in the same product with the same carrier for the following year, but with changes.

Sent in auto renewal batch



Sent in manual renewal



Scenario 5: The applicant completes a manual renewal that impacts only the upcoming year enrollment. The applicant changes enrollment into a new product with the same carrier.



EDI Renewal Code

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

6.2 NEW ENROLLMENTS—OPEN ENROLLMENT

The open enrollment period is an opportunity for new applicants to enroll in a QHP without a qualifying life event. This section discusses processes for new enrollments initiated during the open enrollment period, which will be from November 1 to December 15.

Coverage effective dates

For plans selected during Open Enrollment, the coverage effective date will be January 01 of the upcoming year.

During an open enrollment period, an applicant may change their plan selection multiple times. Consumers are cautioned that changing plans after previously selecting a plan through *Washington Healthplanfinder* may result in multiple communications and invoices from carriers.

Retroactive Enrollment

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

- Error of HBE that resulted in a consumer not being able to enroll for expected coverage date.
- Consumers, who lose coverage outside of *Washington Healthplanfinder*, but report it to HBE within 10 calendar days from the last day of coverage. This will ensure the consumer does not have a gap in coverage.
- Birth, adoption, placement for adoption/foster care, or court order

Special Enrollment Period during Open Enrollment

Existing Applicants:

Changes reported during open enrollment can result in a change to the current year enrollment (including an SEP) and a change or termination to an auto renewed plan. Carriers can expect SEP codes included in 834 transactions for current year and upcoming year transactions during Open Enrollment when the applicant has indicated they have experienced a qualifying life event.

New Applicants:

During open enrollment the applicant can opt to pursue a SEP for an earlier start date than January 1. The applicant must experience a qualifying life event to be considered for a SEP. The start date will be dependent on the event type and date of plan selection.

7 SPECIAL ENROLLMENT PERIODS

7.1 AVAILABILITY

HBE determines SEP eligibility based on applicant experiencing a Qualifying Life Event (QLE). SEPs are accessed multiple ways. The *Washington Healthplanfinder* applicant process will capture some QLEs like Birth or change in program eligibility to determine an individual eligible for an SEP. Other events are captured on the SEP questionnaire and attested by the applicant. Applicants can also request an SEP manual review by HBE. A Presiding Officer may also grant an SEP and determine the start date and length based on the circumstances and facts of the instance.

Carriers may choose to outreach to applicants to verify documentation of certain special enrollment events for which HBE accepts attestation.

Applicants have 60 days from the date of the QLE to make a plan selection. Certain events allow HBE to define the length of an SEP, not to exceed 60 days. Life Events Change of Location and Loss of MEC have advanced availability and can be reported 60 days in advance.

Availability of SEPs for Existing Enrollees:

Existing QHP enrollees who become eligible for an SEP outside of open enrollment are limited to selecting coverage in the same metal level if they choose to change plans. They can choose another carrier, but are still limited to the same metal level of their current enrollment. If there are no other available plans at the same metal level, the enrollee and any dependents can enroll in a plan one metal level higher or lower. This applies to all qualifying life events except for the exceptions below:

Add Dependent: QHP enrolled applicants who become eligible for an SEP due to gaining a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order, must either add the dependent to the existing enrollment or enroll the dependent separately in a different QHP. If the new dependent cannot be added to the enrollee's existing plan, the enrollee can enroll in another plan at the same metal level for which all enrollees are eligible. If there are no other available plans at the same metal level for which all enrollees are eligible, the enrollee can choose a plan one metal higher or lower.

Newly eligible for CSRs: QHP enrollees and their dependent(s) who become newly eligible for CSRs, and are not currently enrolled in a silver metal level plan, will be allowed to change metal levels to a silver plan with the same or new carrier.

American Indian/Alaska Native: AI/AN applicants and their dependent(s) (if enrolled or will be enrolling in the same QHP as the AI/AN applicant) have the option to select any plan during the SEP.

Error of the Exchange: QHP enrolled applicants and their dependent(s) who become eligible for an SEP as a result of Error of the Exchange have the option to select any plan during the SEP.

Domestic Abuse/Spousal Abandonment: QHP enrolled applicants and their dependent(s) who become eligible for an SEP with the triggering event domestic abuse/spousal abandonment have the option to select any plan during the SEP.

Exceptional Circumstances: QHP enrolled applicants and their dependent(s) who become eligible for an SEP with the triggering event Exceptional Circumstances have the option to select any plan during the SEP.

Prior Coverage Requirement

For triggering events including Marriage or Permanent Move, the applicant or their dependent must attest to having been enrolled in minimum essential coverage for at least 1 day in the 60 days prior to the date of the triggering event

7.2 SPECIAL ENROLLMENT QUALIFYING LIFE EVENT

Consumers who apply for coverage outside of an open enrollment period, 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. In general, coverage effective dates are based on a consumer's plan selection date. Plan selected between the 1st and 15th of a month are effective the 1st of the next month. Plans selected between the 16th and 31st (or last day) of a month are effective the 1st of second following month. Certain applicants may be eligible for a retroactive or later effective date based on their qualifying life event.

7.3 VERIFICATION OF SPECIAL ENROLLMENT QUALIFYING EVENTS

SEP Verification Process

Certain qualifying life events will automatically open an SEP when reported through the *Washington Healthplanfinder* application process. 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 *Washington Healthplanfinder* application process, HBE will require documentation of the qualifying life event prior to allowing the consumer to enroll in a QHP/QDP.

Carriers may choose to outreach to consumers to verify documentation of certain special enrollment events for which HBE accepts attestation.

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.

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 9.5 Urgent Discrepancies.

Special Enrollment Qualifying Life Events

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
Adding a Dependent	<p>Includes gaining a dependent or becoming a dependent through:</p> <ul style="list-style-type: none"> • Birth • Adoption • Placement for adoption • Placement in foster care • Receipt of a court order (including child support) 	Date of the birth, adoption, foster care placement, or court order.	02
Marriage	<p>Includes the following:</p> <ul style="list-style-type: none"> • Marriage • Domestic Partnership 	For marriage, coverage is effective the first day of the month following QHP/QDP selection.	32
Losing a Dependent or Dependent Status	<p>Loss of a dependent or loss of dependent status due to death, divorce, or legal separation.</p> <p><i>Note: This SEP is available only to existing enrollees (not first time applicants).</i></p>	<p>For death, coverage is effective the first day of the month following QHP/QDP selection.</p> <p>For divorce or legal separation, coverage start date follows enrollment cutoff (15th) rule.</p>	32
Change in program eligibility or amount of financial help	<p>An enrollee is determined newly eligible or newly ineligible for APTC or has a change in CSR tier.</p> <p><i>Note: This SEP is available only to existing enrollees (not first time applicants).</i></p>	Follows enrollment cutoff (15 th) rule.	FC
Loss of Minimum Essential Coverage (MEC)	<p>Includes the following:</p> <ul style="list-style-type: none"> • Expiration of a non-calendar year health insurance policy, even if the consumer has the option to renew • Loss of pregnancy-related WAH coverage 	<p>Coverage is effective on the first day of the month after the loss of MEC if plan selection occurs before the loss of MEC.</p> <p>If plan selection occurs after the loss of MEC, coverage is</p>	07 or NE

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
	<ul style="list-style-type: none"> • 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) • Loss of Qualified Health Plan due to permanent move • Loss of employer coverage with eligibility for COBRA or expiration of COBRA coverage 	effective the first of the month after plan selection.	
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 (15 th) rule.	NE
Permanently moving from a location in the United States to Washington, or to a new county within Washington, <u>only</u> if you had minimum essential coverage for at least one day within the 60 days before you moved	<p>The move results in:</p> <ul style="list-style-type: none"> • Becoming a resident of Washington • Moving to a new county in Washington resulting in new plan options <p>Consumer can enroll in plan up to 60 days before or after the date of the move.</p>	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 (15 th) 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 (15 th) rule.	43

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 advanced 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. If they later file their taxes, they can regain eligibility for APTC. This allows them an SEP if they are currently enrolled in a QHP without APTC.	Follows enrollment cutoff (15 th) rule.	EX Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.
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 (15 th) 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. NE
Victims of domestic abuse/violence or spousal abandonment and their dependents	Consumer is a survivor of domestic abuse/violence or spousal abandonment. (Marriage to the abuser is not required.) Dependents of 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 15 th rule from plan selection.	07 Carrier should not request documentation of the consumer.
System errors that kept the client from enrolling during SEP or Open Enrollment	<ul style="list-style-type: none"> • System issues must be documented; <u>and</u> • Must have occurred during open enrollment or a 60 day SEP; <u>and</u> 	Coverage may be backdated to the coverage effective date consumer would have received had error not occurred.	ER Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
	Error must have prevented enrollment from occurring during open enrollment or 60 day SEP		
Non-system errors or misconduct of the HBE	<ul style="list-style-type: none"> 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 HBE. 	Coverage effective date is based on the circumstances of the SEP.	ER Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.
Misconduct by a HBE or non-HBE enrollment assister (like an insurance company, navigator, certified application counselor, or agent or broker).	<p>Misconduct resulted in consumer:</p> <ul style="list-style-type: none"> Not getting enrolled in a plan Being enrolled in the wrong plan <p>Not getting the premium tax credit or cost-sharing reduction consumer was eligible for</p>	Coverage effective date is based on the circumstances of the SEP.	ER Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.
Exceptional Circumstances as defined by the HBE	<ul style="list-style-type: none"> The qualified individual or enrollee, or his or her dependent, demonstrates to the HBE that the individual meets other exceptional circumstances as the HBE 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 (15 th rule)).	EX Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.
Unresolved Casework	<p>Consumer is working with HBE staff on an enrollment issue that didn't get resolved before the end of the open enrollment period (Jan. 15, 2018 for 2018 coverage).</p> <p><i>Note: Account worker/case worker who was working with the consumer to try to resolve the issue before the close of OE will open SEP or submit</i></p>	Coverage may be backdated to the coverage effective date consumer would have received had the delay not occurred.	EX or ER Carrier should not request documentation of the consumer. This event is verified and confirmed by HBE.

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
	<i>the case for review after case issue resolved – CSRs do not need to log a ticket.</i>		
WAH to QHP program change	The consumer goes from Washington Apple Health to Qualified Health Plan eligibility	Coverage effective date is backdated to the last day the customer had WAH coverage. The customer may also elect to move the start date forward to the first of the month after plan selection or following the enrollment cutoff (15 th) rule.	PC
Conditional Eligibility Verification after 95-day verification period	The consumer can and does provide documents that verify their conditional status after the 95-day verification period,	The enrollment ID is reinstated with the original effective date	EX

Special Enrollment Correspondence

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 applicant’s dashboard the day after the consumer selects a QHP/QDP.

CHANGING FROM FAMILY TO DEPENDENT COVERAGE OR DEPENDENT TO FAMILY COVERAGE

When an applicant selects a health plan through *Washington Healthplanfinder*, the type of coverage is populated based on which household members the applicant has indicated are seeking coverage. This information is passed in the 834 transaction to the carrier. If the Primary Applicant (PA) is seeking coverage, then the coverage is considered Family coverage (FAM). If the PA is not seeking coverage, then the coverage is considered Dependent-only coverage (DEP).

Existing QHP and QDP enrollees who report a change in seeking coverage for the Primary Applicant will result in a FAM to DEP or DEP to FAM coverage code change. These transactions will generate an 834 termination transaction for the current enrollment and an 834 add transaction with a new enrollment ID for the upcoming enrollment. The premium rating for the new FAM or DEP enrollment will retain the original start date and will not age-rate individuals who have had a birthdate since their coverage started.

The purpose of creating a new Enrollment ID is to automate carrier processing, since HBE enrollments are under the PA rather than a responsible party. Any cost sharing accumulators associated to the prior Enrollment ID should be rolled over to the new Enrollment ID.

FAM to DEP Transition:

- Primary Applicant: Reports a change for the PA to not seeking coverage; which terminates the FAM enrollment following the enrollment cutoff (15th) rule
- Healthplanfinder: Generates 834 termination transaction for the household FAM enrollment
- Healthplanfinder: Generates Termination of Coverage correspondence to the consumer explaining that enrollment was terminated
- Healthplanfinder: Creates a new Enrollment ID with DEP coverage code for remaining QHP/QDP-eligible members, with the same Plan ID effective the 1st of the month following the termination of the original enrollment.
- Healthplanfinder: Generates 834 Add transaction – Subscriber ID remains the same but has the DEP coverage code indicator. Transaction includes a SEP code of 'EX' (Exceptional Circumstance)
- Healthplanfinder: DEP coverage is automatically effectuated if the FAM coverage had been effectuated by the carrier prior to termination.
- Healthplanfinder: Generates Plan Confirmation correspondence to the consumer indicating new enrollment dates and coverage
- Carrier: An 834 confirm transaction is due to HBE within 10 business days of receipt of the first payment under the new Enrollment ID.

DEP to FAM Transition:

- Primary Applicant: Reports a change for the PA to now be seeking coverage.
- Primary Applicant: Indicates they have a qualifying life event (if outside of Open Enrollment) within the last 60 days
- Healthplanfinder: Opens a Special Enrollment Period
- Primary Applicant: Select the same plan. Effective date is based on their qualifying life event
- Healthplanfinder: Generates 834 termination transaction for the household DEP enrollment, terminating the enrollment the date before the effective date of their latest plan selection
- Healthplanfinder: Generates Termination of Coverage correspondence to the consumer explaining that enrollment was terminated
- Healthplanfinder: Creates a new Enrollment ID with FAM coverage code for all QHP/QDP-eligible members, with the same Plan ID
- Healthplanfinder: Generates 834 Add transaction – Subscriber ID remains the same but has the FAM coverage code indicator. Transaction includes a SEP code consistent with their qualifying life event
- Healthplanfinder: FAM coverage is automatically effectuated if the DEP coverage had been effectuated by the carrier prior to termination
- Healthplanfinder: Generates Plan Confirmation correspondence to the consumer indicating new enrollment dates and coverage
- Carrier: An 834 confirm transaction is due to HBE within 10 business days of receipt of the first payment under the new Enrollment ID.

Complicated scenarios exist where changes to the application (including Qualifying Life Events) may result in either a date misalignment or dual enrollment. These cases will be handled manually by HBE Enrollment Analysts to ensure the correct transactions are processed.

8 ENROLLMENT TERMINATIONS AND REINSTATEMENTS

8.1 HBE-INITIATED TERMINATIONS

Explicit Termination: All HBE-initiated enrollment terminations are explicit terminations.

HBE will initiate enrollment terminations for the following reasons:

End of year termination: HBE sends an 834 term file for all active enrollments at the end of the year. End of year file sequencing and timelines are discussed in specific scenarios in the 834 Companion Guide.

26-year old QHP age out: When a dependent turns twenty-six years old, they are no longer eligible to continue enrollment on their parents' QHP. HBE 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 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.

19-year old pediatric dental age out: when a dependent turns nineteen years old they are no longer eligible for coverage in a pediatric-only dental plan. HBE 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.

Determined ineligible for enrollment on the Exchange: HBE will terminate individuals who have been determined ineligible for QHP enrollment and who do not successfully appeal that determination. These transactions will be sent with the termination code 26.

Death: Eligibility must be redetermined in the case that an enrolled household member passes away. HBE will support mid-month terminations of the coverage of deceased individuals. 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 coverage is not disrupted for any remaining household members, and that the monthly premium is adjusted to reflect the reduction in covered household members.

To report such a change and trigger an SEP, which would allow the enrollee to select a new plan for remaining household members, the change must be reported to HBE no later than 60 days after the date of the death. The surviving household members have 60 days from the date of death to select a new QHP/QDP if they elect to change plans. 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 enrollee's eligibility determination will be updated accordingly. However, the enrollee must wait for the next open enrollment period to select a new plan for the next year, or report a different qualifying life event in order to qualify for an SEP.

- Reporting the event initiates three changes to the enrollment: a change in covered household members, an end date for the old premium, and a start date for the new premium.
- Death transactions may result in mid-month disenrollment of the deceased individual. 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.

8.2 APPLICANT-INITIATED TERMINATIONS

Applicants who voluntarily disenroll from coverage will have a coverage end date of last day of the month.

Retroactive Disenrollment:

HBE will support retroactive disenrollment in certain situations. HBE Account Workers will review requests for retroactive disenrollment 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.

Applicants who voluntarily disenroll from coverage will have a coverage end date of last day of the month.

- In this scenario HBE will send the carriers a termination transaction.

The below scenarios may qualify for retroactive disenrollment 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.
- Error of HBE: 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 from multiple applications, overlapping coverage, or multiple enrollments on the same application

8.3 APPLICANT-INITIATED CANCELLATIONS

HBE will send an 834 cancellation file in instances the applicant has contacted HBE to request cancellation prior to the coverage effective date.

10-Day Free Look

Under state insurance regulations (RCW 48.44.230), an applicant who purchases a health or dental plan has a contractual right to return the policy to the issuer for any reason within 10 days of delivery of the policy (or contract) to the applicant. This 10-day period begins on the date the carrier provides the actual insurance policy to the applicant, not on the date the applicant selects a plan in *Washington Healthplanfinder*. Therefore, this date may differ from the coverage effective date.

If the applicant returns the policy within 10 days of the delivery date, it is void from the effective date and any payment for a plan must be refunded to the applicant.

- *Healthplanfinder* does not facilitate delivery of the policy and is unaware of when delivery occurs and the 10-day period begins. The applicant will contact the carrier directly and the two parties should reach an agreement that the "free look" provision applies.

- The carrier will contact the Exchange and request cancellation of the policy through the reconciliation process.
- The Exchange will contact the applicant and confirm that the applicant wishes to cancel. HBE will send an 834 cancellation file.
- If it is outside the open enrollment period, the consumer will not be able to purchase another plan until the next enrollment period. The Exchange will not reinstate the plan or provide a Special Enrollment Period if requested to do so later by the applicant.

8.4 CARRIER-INITIATED TERMINATIONS

Carriers may initiate termination for non-payment of premiums for new and effectuated enrollments. These 834 transactions are sent by the insurance company to HBE.

Grace period lapsed, renewed enrollment, unsubsidized: Unsubsidized applicants who were renewed into their same plan or mapped into a different plan with the same carrier and have a lapsed one-month grace period are cancelled for non-payment by the insurance company. The coverage end date is the last day of the last paid month.

Grace period lapsed, renewed enrollment, subsidized: Subsidized applicants who were renewed into their same plan or mapped into a different plan with the same carrier and have a lapsed three-month grace period are terminated for non-payment by the insurance company. The coverage end date is the last day of the first month of the 3-month grace period.

No binder payment, new enrollment: Applicants who have not made an effectuating payment on a new enrollment are terminated never effective by the insurance company.

Grace period lapsed, effectuated unsubsidized enrollment: Unsubsidized applicants who have made an effectuating payment, and have a lapsed one-month grace period are terminated for non-payment by the insurance company. The coverage end date the last day of the last paid month.

Grace period lapsed effectuated subsidized enrollment: Subsidized applicants who have made an effectuating payment and have a lapsed three-month grace period are terminated for non-payment by the insurance company. The coverage end date is the last day of the first month of the 3-month grace period.

8.5 REINSTATEMENTS

After an applicant confirms their plan selection in *Washington Healthplanfinder*, the system will generate an EDI transaction known as an ADD or 834, which includes information necessary for the Carrier to process the enrollment. Once the Carrier has processed this information, the Carrier will generate an invoice and send it to the client, requesting initial payment. Once the initial payment has been received and processed by the Carrier, the Carrier will send an effectuation transaction. This effectuation transaction will need to pass a series of HIPAA and business validations prior to being added to the daily Extensible Markup Language (XML) and imported into *Washington Healthplanfinder*. If the transaction passes all *Healthplanfinder* technical and business validations, the client's coverage is updated to "Active" status in the *Healthplanfinder* system.

If the applicant does not make their initial payment to the Carrier, or does not make their initial payment timely, the Carrier will not send an effectuation transaction, and will instead send a cancellation for nonpayment

transaction, indicating the enrollee was cancelled as never effective due to nonpayment. In addition, Carriers and HBE staff must be aware of differences between Carrier-initiated and HBE-initiated terminations.

Exceptions: If applicant's account indicates there may be other errors or underlying problems, end-to-end analysis should be completed prior to completing the reactivation process described above in order to ensure there are no additional corrections needed. If these issues are identified on the carrier's end, they should request review by contacting an HBE Enrollment Analyst. HBE will support reactivation of coverage for enrollees 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.

Reactivations - Carrier Reinstatement for Non-Payment: If determined by the insurance company that termination for non-payment was done in error or not warranted, the insurance company will send HBE an 834 Confirm file to reinstate the coverage in an existing calendar year. 834 Confirm files reinstating coverage are due within 10 calendar days of reinstatement occurring.

Reactivations - Carrier Reinstatement of HBE-Terminated Coverage: If a Carrier is requesting reactivation of a HBE-initiated termination, a manual review of the applicant's application must be completed to determine if the enrollee is eligible for reactivation.

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

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

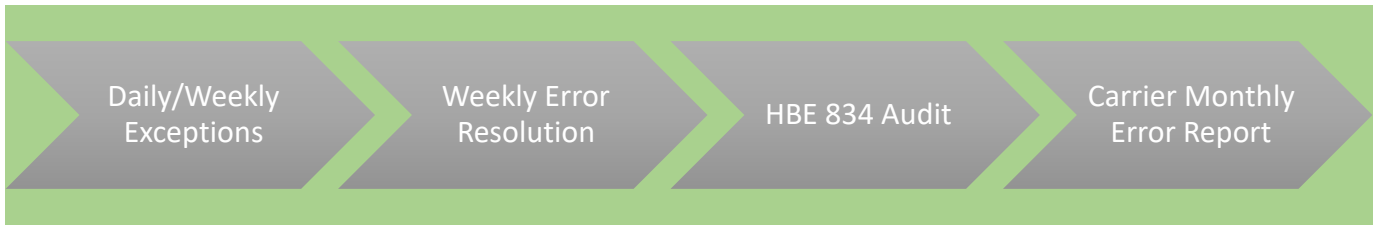
9 RECONCILIATION OF ENROLLMENT DATA

Federal regulations require carriers and HBE to reconcile enrollment data on a monthly basis at a minimum. Currently, HBE utilizes a daily exception process, weekly error resolution, and monthly audit reconciliation processes to resolve enrollment data discrepancies with carriers. The HBE EDI management system, Edifecs, is used to streamline the EDI transmissions with carriers. This is a critical component of the reconciliation process for carriers to generate the monthly 834 audit files. The receipt of the carrier monthly-generated 834-audit file enables 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.

Master monthly discrepancy report will also be an iterative process, dependent on input from both the carrier and the HBE Enrollment Analysts. Carriers should work directly with their assigned HBE Enrollment Analyst and utilize weekly HBE/carrier meetings to provide feedback.

HBE continues to update audit reconciliation process during system releases; HBE will communicate all updates to the carriers in the form of a bulletin.

Previous reconciliation process:



Reconciliation process



9.1 DAILY EXCEPTIONS

If an HBE-generated 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 Enrollment 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 Enrollment Analysts will work EDI exceptions daily to proactively correct EDI errors and enrollment data discrepancies prior to sending transactions to carriers.

9.2 WEEKLY ERROR RESOLUTION

9.2.1 Enrollment Analyst and Carrier 1:1 Meetings

Carriers will work directly with their HBE Enrollment 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 9.5 Urgent Discrepancies below).

Non-urgent discrepancies are expected to be resolved by HBE and Carriers within 5 business days.

9.2.2 HBE and Carrier 1:1 Meetings

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.

9.2.3 HBE All-Carrier Meeting

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; *Washington Healthplanfinder* issues and changes; and all other carrier questions or concerns.

9.3 MONTHLY AUDIT RECONCILIATION PROCESS

Carriers are required to generate and send an 834 Monthly Audit File to HBE which contains all active enrollments. It is a “snapshot” of active enrollments in the carrier’s enrollment system for the benefit month being reported.

HBE also generates Audit transactions, which are delivered to carriers on a monthly basis. Carriers may opt to receive a Standard Audit, a Full Audit, or both.

The goal of the Monthly Audit Process is to identify discrepancies in enrollments between the carrier’s enrollment system and the Edifecs Eligibility Repository. Discrepancy reports are generated by HBE and distributed to carriers so the partners can work together to resolve discrepancies.

9.3.1 Audit Discrepancy Types

There are three types of discrepancies that can result from a monthly audit reconciliation:

1. The enrollee is in the carrier’s 834 Monthly Audit File but is not in the Edifecs Eligibility Repository. This is referred to as “*New in Intake*”.
2. The enrollee is in the Edifecs Eligibility Repository but not in the carrier’s 834 Monthly Audit File. This is referred to as “*Missing from Intake*”.
3. The enrollee is in both the carrier’s 834 Monthly Audit File and the Edifecs Eligibility Repository but there are data discrepancies. This is referred to as “*Differences Found*”.

9.3.2 Monthly Audit Process Flow

The following flow depicts the Monthly Audit reconciliation process at a very high level:



9.3.3 Audit File Generation Timeline

HBE expects carriers to generate and send their 834 Monthly Audit File between the 16th and the 23rd of the month. Similarly, carriers can expect to receive Audit transactions from the HBE within the same time frame.

9.3.4 Audit File Contents

Carrier generated Audit Files and the HBE Standard Audit Files will contain only active members, whose enrollments have been effectuated following generation and receipt of an 834 Confirm transaction. These audits are a “look ahead” at members anticipated to have active coverage on the first day of the following month, also known as the “benefit month”.

The HBE Full Audit Files contain a carrier’s entire enrollment over time, encompassing all subscribers and members, financial change history, along with the current enrollment status and dates of coverage.

9.4 MONTHLY AUDIT DISCREPANCY CATEGORIES

There are different types of discrepancies that may occur in enrollment and/or billing transactions. The table below provides discrepancy categories, definitions, and the responses needed for resolution.

Monthly Audit Discrepancies

Category	Definition	WAHBE Response	Expected Carrier Action
New in Intake	Enrollment is included on the audit unexpectedly (termed or cancelled with WAHBE). Missing from Intake for a particular enrollment coverage year and month.	Non-effectuated enrollment included on carrier audit.	Review enrollment and send confirmation file if enrollment is active.

		Enrollment terminated for non-payment by carrier.	Review enrollment. If enrollment has been reactivated following carrier non-payment term, trigger confirmation file to reactivate.
		Enrollment terminated per HPF.	Process CANCEL/TERM sent by HPF.
		Enrollment cancelled never effective per HPF.	Process CANCEL/TERM sent by HPF.
Missing from Intake	Active/confirmed enrollment is not included on carrier audit.	Confirmed enrollment not included on carrier audit.	Review enrollment and verify enrollment status; and A.) Include on future audit if active; or B.) Send non-payment term.
		Enrollment reactivated by HBE	Reactivate enrollment following HBE add/reinstatement.
		Enrollment reactivated by carrier following non-payment term.	Review enrollment and verify enrollment status. Include on future audit if active.
		Inbound non-payment term failed due to business validation errors.	Review enrollment and verify enrollment status; and A.) Include on future audit if active; or B.) Review transaction and correct errors and resend non-payment term.
Coverage Dates	Subscriber/family enrollment coverage dates are different.	Coverage effective date does not align with system of record.	Review and process CHANGE transactions generated by HPF.
Coverage Level	Subscriber/family enrollment coverage level is different (FAM versus DEP).	Coverage level does not align with system of record.	Review and update enrollment coverage level as transmitted by HPF.
Billing	Billing differences exist for subscriber/family enrollments with current year/month.	Premium does not align with system of record.	Review ADD and/or CHANGE transactions from HPF. Update to align with HPF.

		APTC does not align with system of record.	Review and process CHANGE transactions generated by HPF. Update to align with HPF.
		CSR tier does not align with system of record.	Review and process CHANGE transactions generated by HPF. Update to align with HPF.
		Total responsible amount does not align with system of record.	Review and process transactions generated by HPF. Update to align with HPF.
Member	Differences exist for subscriber/family member information.	Coverage effective date for member does not align with system of record.	Review and process CHANGE transactions generated by HPF.
		End date for member does not align with system of record.	Review and process CHANGE/TERM transactions generated by HPF.

9.5 URGENT DISCREPANCIES

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

New Requests

- **Subject line:** *Carrier Escalation - Subscriber PID*
- **Message:** *Brief description of the request, including the Enrollment ID for the Primary Applicant*

Urgent Requests

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

Requests should never include social security numbers, dates of birth, or member’s name.

HBE and carriers are expected to resolve urgent requests within 1-2 business days.

9.6 PAYMENT REPORTING DURING OPEN ENROLLMENT

Carriers are required to send cumulative payment reports weekly during Open Enrollment. These reports are due Thursday of each week starting November 8, 2018 through March 31, 2019.

Include: All QHP or QDP enrollees who make a payment for 2019 coverage. This includes all renewals and non-renewals and all active and terminated enrollees.

Format: Excel. Carriers may use the suggested template or their own as long as all requested data elements are included.

Method of Delivery: SFTP in the *PaymentRecon* folder. The file should remain in the folder.

Naming Convention: *[Carrier Tax ID]_mmdyyyy_PAYMENT*

Coverage End Dates: If the member is currently active, use 12/31/2019

100% EHB: If APTC covers 100% of the premium, include these members on the report. (Note: carriers should not be receiving anyone with APTC = Premium unless plan is 100% Essential Health Benefits.)

9.7 CMS PAYMENT DISCREPANCIES

Since 2013, HBE has been submitting manual payment workbooks to CMS to make APTC and CSR payments to issuers at the QHP level. CMS has been working with both state-based exchanges and participating carriers since 2016 to transition to a policy-based payment process in which CMS calculates issuer payment amounts at the policy level based on effectuated policy-level enrollment data from the state based exchanges. The data sent by HBE to CMS to calculate policy-based payments is referred to as SBE Incoming files or SBMI.

The policy-based payment process will include:

1. Payment amounts sent to issuers based on policy-level effectuated enrollment data sent by HBE to CMS.
2. Automated payment reports providing payment remittance information at the policy level (Preliminary Payment Report (PPR) and Enrollment Payment System (EPS) extract) and Health Insurance Exchange (HIX) 820 remittance-advice transactions.
3. CMS SBE Payment Dispute Process allowing issuers to report payment discrepancies at the policy level.

In March 2018, HBE completed its transition to policy-based payments in the production environment. This means issuers will receive production 820 transactions for April CMS payments.

HBE will continue to send CMS the manual payment workbooks at the QHP level. CMS will make manual adjustments to the policy-based payments sent to issuers so that the total payments match those calculated using the manual payment workbooks. These adjustments will continue until HBE and CMS establish readiness for payments to be exclusively using the policy-based data sent by HBE to CMS.

The detailed payment reports currently provided by HBE to issuers to reconcile APTC and CSR payments made based on the manual payment workbooks will be phased out. HBE will continue to provide this data to support issuers in their transition to policy-based payments. HBE will work directly with issuers to determine when these detailed reports are no longer needed.

If a carrier identifies discrepancies in the CMS payment amounts, they should follow the current HBE/carrier reconciliation processes to reconcile enrollment and payment data. If discrepancies still exist, the carrier can dispute those payments following the CMS SBE Payment Dispute Process. HBE will also receive a copy from CMS of any disputes filed by the issuers. HBE will review these disputes as part of its ongoing reconciliation processes.

10 APPENDIX A: CARRIER GENERATED AUDIT FILE SCENARIOS

10.1 ASSUMPTIONS

- Although carriers can assign their own premium due dates, these scenarios are based on a carrier assigned premium due date of the last day of the month prior to the effective date of coverage. This applies to either new coverage or continuous coverage.
- These scenarios are based on the assumption that partial payments, even if submitted by the carrier's premium due date, for both initial coverage (binder payment) and ongoing coverage (regular premium payment) are not accepted.
- For those households for whom it is anticipated will be effective the first of the following month, it is recommended that carriers generate and send their 834 Monthly Audit File on or about the 16th day of the month. This applies to either initial coverage or ongoing coverage.
- These scenarios are based on the assumption the carrier generates and sends their 834 Monthly Audit File on the 16th of the month. Because scenarios are also based on the assumption that the carrier assigned premium due date is the last day of the month prior to the effective date of coverage (for both initial coverage and ongoing coverage), there may be Active enrollments included in the 834 Monthly Audit File that are retro-termed during subsequent months.

10.2 SCENARIOS

The following outlines scenarios for what enrollments are included on the 834 Monthly Audit File from the carrier:²⁰

1. A non-subsidy eligible subscriber enrolls on 8/5 for a 9/1 effective date. He makes his binder payment on 8/15.
 - a. New Coverage: Yes
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 8/15
 - d. Benefit Month: September
 - e. Coverage Effective: 9/1
 - f. Coverage Term: 12/31
 - g. Included in Monthly Audit File for: August and subsequent (assuming timely premium payments).
2. A non-subsidy or subsidy eligible subscriber enrolls on 8/5 for a 9/1 effective date. He makes his binder payment on 9/5.
 - a. New Coverage: Yes
 - b. Binder Paid in Full: No
 - c. Last Premium Paid Date: Does not apply

²⁰ This is not an exhaustive list of scenarios.

- d. Benefit Month: September
 - e. Coverage Effective: 9/1
 - f. Coverage Term: 9/1
 - g. Included in Monthly Audit File: No. Grace periods do not apply to binder payments. Generally, most carriers do not effectuate coverage until the binder payment is received. Since the subscriber did not make his binder payment by the payment due date, coverage was canceled. Canceled coverage is not reported on the 834 Monthly Audit File.
3. A non-subsidy or subsidy eligible subscriber has been enrolled since 1/1. He makes his premium payment on 8/15 for September.
 - a. New Coverage: No
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 8/15
 - d. Benefit Month: September
 - e. Coverage Effective: 1/1
 - f. Coverage Term: 12/31
 - g. Included in Monthly Audit File: December (previous benefit year) through August and subsequent (assuming timely premium payments).
4. A non-subsidy eligible subscriber has been enrolled since 1/1. He makes his premium payment late on 9/5 for September, and subsequently fails to make his premium payment for October, thus exhausting his one month premium payment grace period.
 - a. New Coverage: No
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 7/15 (for August)
 - d. Benefit Month: September
 - e. Coverage Effective: 1/1
 - f. Coverage Term: 8/31
 - g. Included in 834 Monthly Audit File: December (previous benefit year) through August. Since the subscriber is not subsidy eligible, a one month grace period is granted. If payment is not received by the last day of September for the month of October, the subscriber is retro-termed back to 8/31, and would not appear on the September 834 Monthly Audit File.
5. A subsidy eligible subscriber has been enrolled since 1/1. He makes his premium payment late on 9/5 for September, and fails to “catch up” his premium payment by the end of November, thus exhausting his 3 month premium payment grace period.
 - a. New Coverage: No
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 7/15 (for August)
 - d. Benefit Month: September
 - e. Coverage Effective: 1/1
 - f. Coverage Term: 9/30
 - g. Included in 834 Monthly Audit File: December (previous benefit year) through November. Since the subscriber is subsidy eligible, a 3 month grace period is granted. If premium payments are

not paid in full by the last day of November for the month of December, the subscriber is retro-termed back to 9/30, and would not appear on the December 834 Monthly Audit File.

6. A subsidy or non-subsidy eligible subscriber enrolls on 8/5 for a 9/1 effective date. He makes a partial payment on 8/15.
 - a. New Coverage: Yes
 - b. Binder Paid in Full: No
 - c. Last Premium Paid Date: Does not apply
 - d. Benefit Month: September
 - e. Coverage Effective: 9/1
 - f. Coverage Term: 9/1
 - g. Included in Monthly Audit File: No. Partial premium payments are not accepted. Grace periods do not apply to binder payments. Generally, most carriers do not effectuate coverage until the binder payment is received. Since the subscriber did not make his full binder payment in a single payment by the binder payment due date, coverage was canceled. Canceled coverage is not reported on the 834 Monthly Audit File.

7. A non-subsidy eligible subscriber has been effective since 1/1. He makes a partial payment on 8/15 for September.
 - a. New Coverage: No
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 7/15 (for August)
 - d. Benefit Month: September
 - e. Coverage Effective: 1/1
 - f. Coverage Term: 8/31
 - g. Included in Monthly Audit File: December (previous benefit year) through August. Partial premium payments are not accepted. Since the subscriber did not make his full premium payment in a single payment by the premium payment due date, coverage was terminated. Terminated coverage is not reported on the 834 Monthly Audit File.

8. A subsidy or non-subsidy eligible subscriber has been enrolled since 1/1. He makes his premium payment on 8/5 for September. Subscriber passes away on 8/15. Death is reported on 9/15.
 - a. New Coverage: No
 - b. Binder Paid in Full: Yes
 - c. Last Premium Paid Date: 8/5 (for September)
 - d. Benefit Month: September
 - e. Coverage Effective: 1/1
 - f. Coverage Term: 8/15
 - g. Included in 834 Monthly Audit File: December (previous benefit year) through August. This is assuming the termination is processed prior to the generation of the September 834 Monthly Audit File.

9. A subsidy or non-subsidy eligible subscriber has been enrolled since 1/1. He makes his premium payment on 8/5 for September. Subscriber passes away on 8/15. Death is reported on 8/20.

- a. New Coverage: No
- b. Binder Paid in Full: Yes
- c. Last Premium Paid Date: 8/5 (for September)
- d. Benefit Month: September
- e. Coverage Effective: 1/1
- f. Coverage Term: 8/15
- g. Included in 834 Monthly Audit File: December (previous benefit year) through July. This is assuming the termination is processed prior to the generation of the August 834 Monthly Audit File.

10.3 SEP SCENARIOS

The following section contains select SEP scenarios that outline the SEP Reason Codes and the 2000, INS04 Maintenance Reason Codes that are reported on 834 transactions:

Please note this is not an exhaustive list of SEP scenarios.²¹

1. An existing household is comprised of a subscriber and dependent spouse. A dependent child is added to the household due to birth, adoption, or court order. *The dependent child is not added to the household's coverage.* This scenario can result in the subscriber and dependent spouse receiving an earlier start date based on the date of birth of the child.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	Dependent Spouse 021 = Add	EC = Member Benefit Selection	02-BIRTH
No	001 = Change	AI = No Reason Given	Dependent Spouse 001 = Change	AI = No Reason Given	02-BIRTH

2. An existing household is comprised of a subscriber and one dependent child. A second dependent is added to the household due to birth, adoption, or court order. *The dependent is added to the household's coverage.*

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	Both Dependents 021 = Add	EC = Member Benefit Selection	02-BIRTH
No	001 = Change	AI = No reason given	Second Dependent 021 = Add	02 = Birth 05 = Adoption or Court Order	02-BIRTH

²¹ Please note that the first column in the scenario tables titled "New Coverage or Plan Change" indicates first time coverage through the HBE or the household's selection of a different plan than they had been covered on previously.

- An existing household is comprised of a subscriber and one dependent child covered through Washington Apple Health (WAH). The subscriber updates the household income, which disqualifies the household from coverage through WAH, but enables them to obtain coverage through HBE. The household is termed from WAH and obtains new coverage through HBE.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	07-TERMINATION OF BENEFITS

- An existing household is comprised of a subscriber and one dependent child covered through HBE. A second dependent covered by WAH loses eligibility for WAH. The second dependent is termed from WAH and added to the household coverage through HBE. Because the second dependent is being added due to loss of medically essential coverage (MEC) the household has the option of staying with their existing plan or moving to a new plan.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	Both Dependents 021 = Add	EC = Member Benefit Selection	PC-WAH TO APTC/QHP
No	001 = Change	AI = No Reason Given	Second Dependent 021 = Add	EC = Member Benefit Selection	PC-WAH TO APTC/QHP

- An existing household is comprised of a subscriber and a dependent child covered through the subscriber's employer health plan. The employer continues to cover the subscriber but discontinues dependent health coverage as a benefit. The subscriber reports his dependent child has lost Medically Essential Coverage (MEC) and is eligible to enroll through HBE.²²

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	07-TERMINATION OF BENEFITS

- An existing household is comprised of a subscriber and a dependent spouse. HBE receives notification of the subscriber death and retro-terms both the subscriber and dependent spouse back to the date of death. The dependent spouse becomes a subscriber on her own coverage with an effective date the first of the following month. A retro-enrollment is manually created to move her coverage start date back to eliminate a gap in coverage.

²² On the 834, 2300, HD05 = DEP is reported for both members indicating dependent only coverage.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes – Initial Add Transaction	021 = Add	EC = Member Benefit Selection	NA	NA	32-MARRIAGE
No – Subsequent Change Transaction	001 = Change	AI = No Reason Given	NA	NA	32-MARRIAGE

7. An existing household is comprised of a subscriber. The subscriber marries and adds the new dependent spouse to the household coverage.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	32-MARRIAGE
No	001 = Change	AI = No Reason Given	021 = Add	32 = Marriage	32-MARRIAGE

8. An existing household is comprised of a subscriber and a dependent spouse. The subscriber reports the dependent spouse death.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	NA	NA	32-MARRIAGE
No	001 = Change	AI = No Reason Given	024 = Cancel/Term	03 = Death	32-MARRIAGE

9. An existing household is comprised of a subscriber and a dependent spouse. The subscriber reports an address change that moves the household to a new service area. In one scenario this change could result in the unavailability of the household's current plan. Conversely, their current plan is still available but due to the move the household may have the option of selecting a different plan offered in the new service area.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	43-CHANGE IN LOCATION

10. An existing household is comprised of a subscriber and a dependent spouse. A SEP is opened for the household due to exchange error.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	ER-EXCHANGE ERROR
No	001 = Change	AI = No Reason Given	001 = Change	AI = No Reason Given	ER-EXCHANGE ERROR

11. An existing household is comprised of a subscriber and a dependent spouse. Their existing plan is decertified and no longer available through HBE. The household is termed from their existing plan and re-enrolls in an available plan.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	EX-EXCEPTIONAL CIRCUMSTANCES

12. An existing household is comprised of a subscriber and a dependent spouse. The subscriber removes his dependent spouse from the household coverage due to divorce and opts to stay with the same plan or move to another plan. This results in the dependent spouse being termed off of her original plan and enrolling as the subscriber on a new plan.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
No – for subscriber one (original subscriber)	001 = Change	AI = No Reason Given	024 = Term	07 = Termination of Benefits	32-MARRIAGE
Yes – for subscriber one (original subscriber)	021 = Add	EC = Member Benefit Selection	NA	NA	32-MARRIAGE
Yes for subscriber two (former dependent spouse)	021 = Add	EC = Member Benefit Selection	NA	NA	07-TERMINATION OF BENEFITS

13. A household reports a substantive change in income that results in a change to APTC and/or CSR amounts.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	FC-FINANCIAL CHANGE

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
No	001 = Change	AI = No Reason Given	NA	NA	FC-FINANCIAL CHANGE

14. An existing household is comprised of a subscriber and a dependent spouse. The dependent spouse reports Domestic Violence and enrolls as her own subscriber on a new plan.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes – (former dependent spouse)	021 = Add	EC = Member Benefit Selection	NA	NA	07-TERMINATION OF BENEFITS

15. An individual is released from incarceration or has a change in citizenship status that results in their eligibility for coverage through HBE.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	NA	NA	NE-NEWLY ELIGIBLE

16. An individual has a change in tax filing status which results in their eligibility for coverage through HBE.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	NA	NA	NE-NEWLY ELIGIBLE

17. A household with at least one tribal member opts to enroll or change plans.

New Coverage or Plan Change?	2000, INS03 Subscriber	2000, INS04 Subscriber	2000, INS03 Dependent(s)	2000, INS04 Dependent(s)	2700/2750 Loop SEP REASON Code
Yes	021 = Add	EC = Member Benefit Selection	021 = Add	EC = Member Benefit Selection	NE-NEWLY ELIGIBLE

11 APPENDIX B: SAMPLE – HBE HARDSHIP EXEMPTION LETTER

Re: Request for health care coverage information

Dear XX:

Thank you for letting us know that you had difficulties getting health insurance coverage through the Washington Health Benefit Exchange. Per your request, this letter is to confirm that our records show the following information in your account:

- On (DATE), your original application for health care coverage was submitted through Healthplanfinder.
- You enrolled in (Plan Name) with a start date of (DATE).
- On (DATE), technical difficulties on the part of Washington Healthplanfinder affected your (ELIGIBILITY/ENROLLMENT), resulting in termination of your enrollment effective (DATE).
- This letter is to support your application for an exemption from the Shared Responsibility Mandate from (DATE) to (DATE).

To apply for a hardship exemption, you must submit an application for an exemption to the U.S. Department of Health and Human Services (HHS). **Please note that applications for exemptions are currently processed by the federal government, not the Washington Health Benefit Exchange.**

You may submit this letter as documentation in support of your hardship exemption application. More information, including the exemption application form, is available at: <https://www.healthcare.gov/fees-exemptions/hardship-exemptions/>. The federal Health Insurance Marketplace Call Center can be reached at 1-800-318-2596 (TTY 1-855-889-4325).

Other types of exemptions may be available from either the Internal Revenue Service (IRS) or U.S. Department of Health and Human Services (HHS) depending on the type of exemption. For general information about exemptions, visit the IRS exemptions webpage at: <http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Exemptions>.

Please contact me directly if you have any additional questions or concerns.

Sincerely,

Washington Health Benefit Exchange