Washington Health Benefit Exchange
521 Capitol Way South
Olympia, Washington 98501

GUIDANCE FOR PARTICIPATION IN THE WASHINGTON HEALTH BENEFIT EXCHANGE

February 1, 2013

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SECTION I: INTRODUCTION

This Guidance for Participation specifies how a health insurance issuer can participate in the Washington Healthplanfinder, Washington's State Health Benefit Exchange (HBE).

The Guidance will provide information on the following:

- Certifying and recertifying a health plan to become a Qualified Health Plan (QHP) offered through the Exchange;
- Monitoring and compliance of QHPs;
- Decertifying a QHP;
- Special guidance for coverage of American Indian/Alaska Natives;
- Guidance on enrollment and billing;
- Guidance on participating in the Small Business Health Options Program (SHOP).

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of state-based and administered Health Benefit Exchanges. The Washington State Legislature and Governor Gregoire established HBE and the Board by enacting Substitute Senate Bill 5445. HBE is governed by an eleven member Board consisting of eight voting Board members, a ninth member as the Chair who only votes in the case of a tie, plus two non-voting, ex-officio members, the Washington State Insurance Commissioner and the Administrator of the Washington State Health Care Authority.

Engrossed Second Substitute House Bill 2319 authorized the Board to govern the Exchange and to certify QHPs offered through the Exchange. On June 13, 2012, the Board adopted nineteen criteria to certify QHPs to be offered through Healthplanfinder.

HBE has been working closely with stakeholders, sovereign nations, and federal and state agencies, to ensure that Healthplanfinder will be ready to perform open enrollment of health insurance plans beginning October 1, 2013. Likely, 100,000 to 400,000 Washington residents could become insured in individual or SHOP plans purchased through Healthplanfinder.

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

1.1 Glossary

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

"ACTUARIAL VALUE"

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

"AFFORDABLE CARE ACT"

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

"APPEAL"

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

"DECERTIFY"

A decertified QHP will no longer be offered on Healthplanfinder and the QHP issuer must terminate coverage of the enrollees after providing notice and after special enrollment has been offered to the plan's enrollees (45 CFR §156.290).

"ENROLL"

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

"ENROLLEE"

Qualified individual or qualified employee enrolled in a QHP.

"EXPIRE"

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

"HEALTH BENEFIT EXCHANGE BOARD"

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

"HEALTH INSURANCE ISSUER OR ISSUER"

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

(In this document, Issuer refers to a health insurance company, Product to a suite of plans that share, for example, a common element such as health benefits, and Health Plan as the most granule level and referring to the actual insurance coverage purchased by a consumer. The document never refers to health insurance companies as "the plans" or "the health plans.")

"HEALTH PLAN"

Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA. A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan has a defined set of covered benefits and cost-sharing, and multiple health plans can be associated with a single product.

1.1 Glossary
(Continued)

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

"INITIAL OPEN ENROLLMENT PERIOD"
The initial open enrollment period offered to applicants from October 1, 2013 through March 31, 2014 to enroll in Individual QHPs through Healthplanfinder for coverage in the 2014 plan year.

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

"OPEN ENROLLMENT"
Annual open enrollment period offered by Healthplanfinder from October 15 through December 7 of the calendar year that precedes the benefit year. During open enrollment, a qualified individual may enroll in a new QHP.

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

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

"PRODUCT" – A suite of Health Plans that share common benefits, formulary, provider network, and additional features. Cost sharing and rates vary at the Plan level.

"QUALIFIED HEALTH PLAN OR QHP"
A health plan that is certified by an Exchange, and is a commitment to insure essential health benefits under specific cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

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

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

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

1.2 Overview of Guidance

1.2.1 Objective

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

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

- Be approved by the OIC;
- Satisfy the certification criteria adopted by the Board; and
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156.

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

1.2.2 Term of Engagement

An Individual or SHOP health insurance plan certified as a QHP will be offered through Healthplanfinder beginning October 1, 2013 with an initial effective date of coverage beginning no sooner than January 1, 2014.

Health insurance issuers, responding to this Guidance, will offer certified QHPs for a term of one year beginning January 1, 2014 and ending December 31, 2014. Only OIC-approved health plans certified by the Board may be offered as QHPs through Healthplanfinder during this period.

1.2.3 Contact

Your contact at HBE for this document is Susanne Towill, Senior Plan Manager, Operations Division. Please direct all questions regarding plan management and this document to Susanne Towill at (360) 407-4162 or QHP@wahbexchange.org.

1.2 Overview of Guidance
(Continued)

1.2.4 Plan Management Timeline and Letter of Intent

An issuer is recommended to inform HBE of its intent to participate in Healthplanfinder. This letter of intent is nonmandatory and nonbinding, but will help the HBE prepare for the certification process and the initial open enrollment.

HBE is not requesting that an issuer inform HBE of the specific health plans it intends to offer through Healthplanfinder. Please, however, inform HBE of the markets (Individual and/or SHOP) in which your organization intends to offer QHPs.

Please submit your letter of intent via e-mail to HBE at QHP@wahbexchange.org by the date shown in Table 1: Plan Management Timeline.

Table 1: Plan Management Timeline

These dates are subject to change based on federal regulations.

HBE releases Draft Final Guidance for Participation	December 21, 2012 Feedback due by January 11, 2013
Email non-mandatory, non-binding letter of intent to participate in Healthplanfinder	January 22, 2013
HBE issues Final Guidance for Participation HBE Releases Draft QHP Issuer Submission Checklist	February 1, 2013 February 8, 2013,
	feedback due by February 18, 2013
HBE issues Final QHP Issuer Submission Checklist	March 1, 2013
HBE Releases Draft HBE Participation Agreement	March 23, 2013, feedback due by April 20, 2013
HBE and OIC perform QHP certification and regulatory review processes	April 1, 2013 – July 31, 2013
HBE issues Final HBE Participation Agreement	May 1, 2013
QHP issuers submit signed Participation Agreement to HBE	July 19, 2013
HBE Board certifies QHPs for 2014	July 24, 2013 Board meeting August 21, 2013 Board meeting
QHP issuers satisfy any remaining QHP certification criteria to HBE staff	August 9, 2013
QHP issuers ratify QHP benefit and rate data in HBE Product Center system	September 4, 2013 – September 21, 2013
QHPs available for SHOP employers to select for initial effective date of January 1, 2014	October 1, 2013
QHPs available in Healthplanfinder for an initial effective date of January 1, 2014	October 1, 2013

1.3 Participating in Healthplanfinder

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

1.3.1 Initial Certification of Qualified Health Plans

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

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

An issuer will need to enter into a Participation Agreement with HBE before offering QHPs through Healthplanfinder. The terms of the Participation Agreement will incorporate the health plan certification criteria described in this Guidance, and will further identify the respective roles, responsibilities, and obligations of participating issuers and HBE. HBE reserves the sole discretion to establish, modify, and amend QHP certification and decertification criteria, terms, and conditions at any time up to and including the execution of issuer Participation Agreements.

Prior to plan publishing, an issuer will need to enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and then one or more EDI interfaces will need to be tested with the issuer. These steps will ensure that the Issuer and Exchange will be able to communicate enrollment to and from each other. The specific details for this operational readiness process are forthcoming.

1.3.2 Recertification of Qualified Health Plans

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

1.3.3 Submitting Health Plans to Become Certified as a QHP

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

SECTION II: SPECIFICATIONS FOR HEALTHPLANFINDER PARTICIPATION

2.1 Summary of Initial Certification and Recertification Criteria

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

Table 2

Summary of Initial Certification and Recertification Criteria

No.	Criteria Level	Criteria	Reviewed by OIC or HBE?	Initial Certification Criteria	Recertification Criteria?
1.	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2.	Issuer	Issuer must pay user fees, if QHPs assessed	HBE	Yes	Yes
3.	Issuer	Issuer must comply with the risk adjustment program	HBE	Yes	Yes
4.	Issuer	Issuer must comply with market rules on offering plans	OIC	Yes	Yes
5.	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6.	Issuer	Issuer must be accredited by an entity that the federal Department of Health and Human Services recognizes for accreditation of health plans within the specified timeframe	HBE	Yes	Yes
7.	Product	QHP must meet marketing requirements	HBE	Yes	Yes
8.	Product	QHP must meet network adequacy requirements which will include essential community providers	OIC	Yes	Yes
9.	Product	Issuer must submit health care provider directory data	HBE	Yes	Yes
10.	Product	Issuer must implement a quality improvement strategy	HBE	Yes	Yes
11.	Product	Issuer must submit health plan data to be used in a standard format for presenting health benefit plan options	HBE	Yes	No
12.	Product	Issuer must implement quality and health performance measures made available to Healthplanfinder consumers	HBE	Not yet applicable	Not yet applicable
13.	Product	Issuer must use a standard enrollment form	OIC	Yes	Yes
14.	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15.	Product	Services provided under a QHP through a Direct Primary Care Medical Home must be integrated with the QHP issuer	OIC	Yes	Yes
16.	Plan	A QHP must comply with benefits design standards (e.g., cost sharing limits, "metal level" (Platinum, Gold, Silver, or Bronze), essential health benefits)	OIC	Yes	Yes
17.	Plan	Issuer must submit to the HBE a QHP's service area and rates for a plan year	OIC	Yes	Yes
18.	Plan	Issuer must post justifications for QHP premium increases	HBE	No	Yes
19.	Plan	Issuer must submit to the HBE QHP benefit and rate data for public disclosure	HBE	Yes	Yes

2.2 QHP Specifications

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

2.2.1 Licensed and Good Standing

An issuer must have un-restricted authority to write its authorized lines of business in Washington in order to be considered "in good standing" and to offer a QHP through the Exchange. The OIC is the sole source of a determination of whether an issuer is in good standing. Please direct requests for a certificate of good standing to companysupervisionfilings@oic.wa.gov.

OIC determinations of good standing will be based on authority granted to the OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

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

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

2.2.2 User Fee Adherence

HBE has received federal grant funds to administer Healthplanfinder through 2014. The Washington State Legislature, in ESSHB 2319, directed the Board to develop a methodology to ensure HBE is self-sustaining after December 31, 2014. On December 1, 2012, the Board submitted recommended funding methodologies to the Legislature.

Dependent on actions taken by the legislature in 2013, the collection of issuer fees would likely begin sometime in 2014, funding the administration of HBE in 2015.

If a QHP issuer is directed to begin paying such fees, then HBE must monitor the payment of those fees and take corrective action when necessary. If a QHP issuer's payment is delinquent, then HBE may assess a penalty. HBE will assess a penalty equal to 1%, rounded up to the nearest whole dollar, of the issuer's delinquent amount for each 15-day period that an issuer's payment is overdue. To avoid penalties for late payment, a QHP issuer is encouraged to pay any fee assessed while contesting the fee.

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

2.2.3 Risk Adjustment Program

A QHP issuer must comply with the requirements of the risk adjustment program as specified in the ACA, federal rules, rules adopted by the OIC, and the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS) or the OIC.

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

2.2 QHP Specifications
(Continued)

2.2.4 Market Rules for Offering QHPs

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

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

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

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level.
- An issuer must offer a child-only plan at the same level of coverage as any QHP (which does not include catastrophic plans) offered through Healthplanfinder (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.
- A health plan meeting the definition of a catastrophic plan in RCW 48.43.005 may only be sold through Healthplanfinder.

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

2.2.5 Non-discrimination

A QHP issuer must comply with federal and Washington State non-discrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.200(e)). (At the time of publishing this document, proposed rule §156.125 specifies that an issuer may not provide essential health benefits if its benefit design also discriminates based on an individual's degree of medical dependency or quality of life.)

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

2.2.6 Accreditation

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

For the initial QHP certification process for offering coverage in the 2014 plan year, HBE will certify a health plan as achieving accreditation if one of the following statuses is held by an issuer for commercial insurance or Medicaid products:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim is a new

18-month Exchange accreditation offered by NCQA). HBE will not recognize these NCQA statuses: denied, appealed by issuer, in process, revoked, scheduled, suspended, or expired.
- URAC: full, conditional, provisional, or corrective action. HBE will not recognize this URAC status: denial.
- Full accreditation by other organizations designated by the United States Department of Health and Human Services.

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

- When submitting a health plan for certification, an issuer must attest that it will schedule the "Exchange accreditation" in the plan types (HMO, MCO, POS, or PPO) used in offering its QHPs.
- A QHP issuer must achieve "Exchange accreditation" and make proof of that accreditation available before the beginning of the QHP issuer's third certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2014 plan year, then it would need to achieve and document "Exchange accreditation" by the beginning of the certification process to be performed by HBE in 2016 for offering QHP coverage in the 2017 plan year.

After January 1, 2014, a QHP issuer must achieve the URAC or NCQA Exchange accreditation by the first accreditation renewal date after the QHP issuer's third certification process. (HBE will update this requirement if the United States Department of Health and Human Services designates additional accrediting organizations.)

If a QHP issuer does not maintain accreditation of a QHP as defined by HBE, then HBE must decertify that QHP.

2.2.7 Marketing

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

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

QHP issuers will be expected to create marketing

2.2 QHP Specifications
(Continued)

and enrollment materials in advance of the October 1, 2013 open enrollment date and HBE will provide further instructions about submitting the materials.

Marketing materials will be pulled from Healthplanfinder web pages if they do not conform with the standards set through this criterion.

2.2.8 Network Adequacy

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

- The network is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-43-200.

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system. Hospital contracts must comply with this provision by January 1, 2015.

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

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

2.2.9 Provider Directory

A QHP issuer must contribute data on the health care providers that participate in networks associated with a QHP. HBE will provide specifications on submitting health care provider data to prospective QHP issuers.

2.2.10 Quality Improvement Strategy

To satisfy this criterion, a QHP issuer needs to document implementation of each of the quality improvement strategies in §1311(g)(1) of the ACA:

- Improve health outcomes. The issuer must describe activities implemented to improve health outcomes, including quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (e.g., implementation of a medical home model for treatment or services).
- Prevent hospital readmissions. The issuer must describe its implementation of a comprehensive hospital discharge program to prevent hospital readmissions. The program may include patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.
- Improve patient safety/reduce medical errors. The issuer must describe activities implemented to improve patient safety and reduce medical errors. Such activities may

2.2 QHP Specifications
(Continued)

include the appropriate use of clinical best practices, evidence based medicine, and health information technology.

- Improve wellness and health promotion. The issuer must describe the implementation of wellness and health promotion activities.
- Reduce health disparities and health care disparities. The issuer must describe activities implemented to reduce health and health care disparities. Such activities may include the use of language services, community outreach, and/or cultural competency trainings.

HBE will provide a QHP issuer with a form to submit quality improvement strategies. The submitted strategies will be posted for consumers on the Healthplanfinder web pages. If a quality improvement strategy changes, then a QHP issuer will resubmit the form with updated quality improvement strategies within 30 days.

HBE intends to implement a quality rating system for QHPs and to publish these ratings on Healthplanfinder web pages. In order to meet this criterion 2.2.10, HBE expects that a QHP issuer will need to participate in the reasonable implementation of this rating system, including the disclosure and reporting of information on health care quality and outcomes described in §1311(c)(1)(H) and §1311(c)(1)(I) of the ACA, and the implementation of appropriate enrollee satisfaction surveys consistent with §1311(c)(4) of the ACA (45 CFR §156.200(b)(5)).

2.2.11 Standard Format for Presenting Health Benefit Plan Options

HHS will furnish the federally-established standard form for presenting health plan options. If HHS does not supply a standard form, HBE will use information from the summary of benefits and coverage.

2.2.12 Quality Measures

The criterion specifies the collection of information on QHPs, and consequently, the criterion cannot be implemented until after QHPs have offered coverage through Healthplanfinder and quality measures have been collected.

HBE is in the process of specifying the quality measures to be collected. QHP issuers will begin collecting the quality data in the 2014 plan year. HBE will display those measures to consumers during the open enrollment period conducted in 2015 for QHP selections made for the 2016 plan year.

2.2.13 Standard Enrollment Form

QHP Issuers will use the federally-established standard enrollment form furnished by HHS to satisfy this criterion.

2.2.14 Hospital Patient Safety Contracts

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

2.2 QHP Specifications
(Continued)

2.2.15 Direct Primary Care Medical Homes

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

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

2.2.16 Benefit Design Standards

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

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

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

2.2.17 Service Areas and Rating Requirements

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

2.2.18 Posting Justifications for Premium Increases

QHP issuers are required to post justifications for specific premium increases as directed by the OIC. The OIC drafts and posts its own summary of the premium increase justification for the public. To provide information to applicants and enrollees, HBE will link to the OIC summaries on specific premium increases. The act of linking to those summaries will satisfy this criterion for an issuer submitting a plan to become a certified QHP.

2.2.19 Reporting Data

A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, plan benefit and rate data to the OIC using SERFF. The OIC will forward the data for approved plans to HBE. A QHP issuer will satisfy this criterion by submitting benefit and rate data to HBE to be used in the consumer shopping experience.

2.3 Pediatric Dental Essential Health Benefit

Engrossed Second Substitute House Bill 2319 specifies that Healthplanfinder will offer stand-alone pediatric dental plans. The bill further specifies that pediatric dental benefits must be offered and priced separately to assure transparency for consumers through Healthplanfinder. Please refer to the OIC for further guidance on setting the rate for pediatric dental.

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.1 Summary Table 3: Monitoring and Compliance of Qualified Health Plans

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

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

2.4 Monitoring and Compliance of Qualified Health Plans
(Continued)

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

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.2 Summary Table 4:
Key Decisions That Alter the Offering of Enrollment in a QHP

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

No.	Decision	Notice or Request	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
1	QHP Issuer closes QHP to new enrollment.	QHP Issuer requests approval from HBE.	No. New enrollees may not select the closed QHP during open enrollment However, the current enrollees may select to retain the closed QHP during open enrollment.	A closed QHP must provide special enrollment for qualifying events of own enrollees. A closed QHP will not participate in special enrollment for enrollees of other QHPs or new enrollees.	No	No	Yes. The QHP must participate in and become recertified to continue offering through Healthplanfinder.
2	QHP issuer elects not to seek recertification of a QHP.	QHP issuer informs HBE at recertification.	N/A	N/A	N/A	No. However, enrollment ends at the end of the plan year. To remain covered through Healthplanfinder, an enrollee must select a different QHP for the next plan year during open enrollment.	No, the QHP expires.

2.4 Monitoring and Compliance of Qualified Health Plans
(Continued)

3	HBE denies recertification of a QHP.	HBE notifies QHP issuer before open enrollment.	N/A	N/A	N/A	No. However, enrollment ends at the end of the plan year. To remain covered through Healthplanfinder, an enrollee must select a different QHP for the next plan year during open enrollment.	No
4	QHP issuer discontinues QHP and removes QHP from the market.	QHP issuer provides 90-day notice to OIC and HBE.	N/A	N/A	Yes	Yes. Coverage terminated only after HBE offers special or open enrollment.	N/A
5	QHP issuer discontinues all plans in a market and exits that market.	QHP issuer provides 180-day notice to OIC and HBE.	N/A	N/A	Yes	Yes. Coverage terminated only after HBE offers special or open enrollment.	N/A
6	OIC withdraws health plan approval and issuer removes QHP from the market.	OIC informs HBE when approval is withdrawn.	N/A	N/A	Yes	Yes. Coverage terminated only after HBE offers special or open enrollment.	N/A
7	HBE decertifies a QHP.	HBE notifies an issuer that a QHP or QHPs are decertified. HBE notifies enrollees in coordination with the QHP Issuer.	N/A	N/A	Yes	Yes	N/A

2.5 Description of Key Decisions

2.5.1 A QHP Issuer Closes a QHP to New Enrollment

A QHP issuer must request approval to close a QHP to new enrollment at least 30 days before the effective date of closing. The QHP issuer must enroll any new enrollees "in the pipeline" with effective dates after the date of closure. HBE will no longer offer a closed QHP during open enrollment and current enrollees may enroll in any other QHP during open enrollment.

A closed QHP must continue to provide special enrollment to enrollees with qualifying events. A closed QHP, however, will no longer participate in the special enrollment activities when enrollees of other QHPs or new enrollees experience qualifying events.

To be offered through Healthplanfinder, a closed QHP must continue to achieve annual recertification.

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

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

A QHP issuer must notify HBE before the beginning of the recertification process of the intent to let a QHP certification expire. The expiring QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year. A QHP set to expire must fulfill the obligations set forth in 45 CFR §156.290 which include providing coverage until the end of the plan year.

Once expired, the QHP issuer may never again offer that QHP through Healthplanfinder.

2.5.3 HBE Denies Recertification of a QHP

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

The denied QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year. A QHP issuer may never again offer that denied QHP through Healthplanfinder.

2.5.4 A QHP Issuer Discontinues a QHP Mid-year and Removes the QHP from the Market

A QHP issuer must provide formal notice to HBE that a QHP will be discontinued. The QHP issuer must provide the formal notice 15 calendar days before enrollees receive the "90-day" notice required in RCW 48.43.035 for SHOP QHPs and RCW 48.43.038 for Individual market QHPs.

HBE must decertify the QHP as set forth in 45 CFR §156.270, 45 CFR §156.290, and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after HBE has notified the enrollees within the same 90-day timeframe

2.5 Description of Key Decisions
(Continued)

specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in special or open enrollment as set forth in §156.290. A QHP issuer may never again offer the discontinued QHP through Healthplanfinder.

The direction provided in this section – to "discontinue and perform special or open enrollment" for QHPs – does not change the requirements in RCW 48.43.035 and RCW 48.43.038 for issuers to perform "discontinue and replace" for plans outside of Healthplanfinder.

2.5.5 A QHP Issuer Discontinues All QHPs in a Market Mid-year and Exits that Market

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

HBE must decertify the QHPs as set forth in 45 CFR §156.270, 45 CFR §156.290, and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after HBE has notified the enrollees within the same 180-day timeframe specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in special or open enrollment as set forth in 45 CFR §156.290. A QHP issuer may never again offer a discontinued QHP through Healthplanfinder.

2.5.6 OIC Withdraws Plan Approval and QHP Issuer Removes QHP from the Market

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

HBE must decertify the QHPs and the QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer a withdrawn QHP through Healthplanfinder.

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

2.5.7 HBE Decertifies a QHP

HBE may determine that a QHP no longer satisfies the certification criteria of a QHP and decertify the plan. HBE must notify a QHP issuer when a QHP is decertified.

The QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer a decertified QHP through Healthplanfinder.

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

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

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

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

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

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

SECTION IV: SHOP SPECIFICATIONS

HBE will establish a Small Business Health Options Program (SHOP). HBE will certify QHPs to be offered through SHOP and determine employer eligibility, support employee open enrollment and special enrollment, and perform premium aggregation through the billing and collection of employer premium payments.

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

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

Based on federal requirements, the SHOP must:

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

SECTION V: ISSUER APPEAL PROCESS

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

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

An issuer's appeal must:

1. Identify the specific criterion or criteria appealed;

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

3. Succinctly state the outcome sought by the issuer.

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

SECTION VI: ISSUER CUSTOMER SERVICE

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

An issuer will also provide customer service representatives during normal business hours to assist consumers, respond to inquiries from potential enrollees, and coordinate customer service between its own representatives and with HBE, producers, and other third-party representatives.

SECTION VII: ENROLLMENT IN A QHP

7.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the HBE Enrollment and Payment Process Guide. Please see the guide for additional details.

7.2 Premium Aggregation

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

HBE must aggregate premiums for a QHP offered through SHOP.

A QHP issuer must agree to comply with standards and processes established for either market by HBE for the collection and aggregation of premiums, funds transfer, reconciliation, financial accounting, and reporting.

7.3 Advanced Payment of Tax Credit Specifications

Issuers will be expected to comply with the enrollment and payment processes outlined in the Healthplanfinder Enrollment and Payment Process Guide. Please see the guide for additional details.

7.4 Cost Sharing Subsidy Specifications

Issuers will be expected to comply with the enrollment and payment processes outlined in the Healthplanfinder Enrollment and Payment Process Guide. Please see the guide for additional details.

7.5 Producer and Navigator Specifications

7.5.1 Producer

[Placeholder for possible future content should HBE play a role in support of producer services in Healthplanfinder]

7.5.2 Navigator

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

SECTION VIII: ENROLLEE GRIEVANCE PROCESS

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

APPENDIX I
QHP CERTIFICATION DATA AND DOCUMENT CHECKLIST

This checklist is provided to assist an issuer when submitting health plans for certification as a QHP. Please use this form to ensure that all required information has been submitted - not including the required information may result in denial of certification of a health plan. The checklist may be updated by HBE and the revised list distributed to issuers.

Information required for Certification	Data	Document	Submittal Process/Source/Due Date	Submitted
Non-binding Letter of Intent	No	Yes	Submit to HBE: Email Due 1/22/13	☐
Issuer Submission Checklist Form: 1. Issuer Profile Information 2. Accreditation Entity 3. Proposed Product, Plan, & Metallic Level Summary Information 4. Logo 5. OIC-issued Certificate of Good Standing	No	Yes	Submit to HBE: Mail or Email Due on or before 4/1/13 (should coincide with OIC Initial Form Filing)	☐
CMS Data Templates – 1. Administrative Info 2. Rating Data (tables and supporting business rules) 3. Rate Review, Market wide Information 4. Plan & Benefits 5. Prescription Drug 6. Network 7. Essential Community Providers (ECP) 8. Service Area	Yes	No	Submit to OIC: SERFF Product Binder Due on or before 5/1/13 OIC sends to HBE upon approval (If OIC unable to forward to HBE, then Issuer submits directly to HBE after receiving OIC approval)	☐
Participation Agreement Form: 1. Attestations 2. EDI Trading Partner Agreement 3. Marketing Brochures 4. Quality Improvement Strategy Form	No	Yes	Submit to HBE: Mail or Email 7/19/13	☐
Health Care Provider Directory Data	Yes	No	Submit to HBE: Provider Directory File Due 6/24/13	☐
Summary of Benefits and Coverage (SBC) for each OIC approved QHP	No	Yes	Submit to HBE: SBC PDF Due on or before 7/31/13	☐

APPENDIX II
FEDERAL REQUIREMENTS

Detailed Federal guidance is available on the website of The Center for Consumer Information & Insurance Oversight (CCIIO), http://cciio.cms.gov/resources/regulations/index.html#hie.

REQUIREMENT CATEGORY	FEDERAL REQUIREMENT	**REFERENCE**
Licensing	State Licensure	45 CFR §156.200(b)(4)
Accreditation	General requirement	45 CFR §156.275(a)
Accreditation	Timeframe for Accreditation	45 CFR §156.275(b)
Health care quality requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
Health care quality requirements	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
Health care quality requirements	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
User Fee Adherence	Requirement for Exchange user fees	45 CFR §156.50(b), 155.160
Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
Actuarial Value Designation	Actuarial Value Standards	Federal guidance not yet final
Offering requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
Offering requirements	Child-only plan	45 CFR §156.200(c)(2)
Rating variations	Product Pricing	45 CFR §156.255(b)
Rating variations	Allowable Variability	45 CFR §156.255(a)
Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
Marketing	Non-discrimination	45 CFR §156.225(b)
Abortion Services	Compliance with State Abortion Laws	45 CFR §16.280(a)
Abortion Services	Abortion Funds Segregation	45 CFR §156.280
Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
Premium Rate and Benefit Information	Rate submission	45 CFR §156.210 (b)

Premium Rate and Benefit Information	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
Premium Rate and Benefit Information	Rate Increase Consideration	45 CFR §155.1020 (b)
Premium Rate and Benefit Information	Benefit and Rate Information	45 CFR §155.1020(c)
Service Area	Minimum Service Area	45 CFR §155.1050(a)
Service Area	Non-Discriminatory Service Area	45 CFR §155.1050(b)
Network Adequacy	Network Adequacy Standards	45 CFR z156.230
Network Adequacy	Provider Directory	45 CFR §156.230(b)
Enrollment Processes and Periods	Enrollment Periods	45 CFR §156.260 (small employer: 45 CFR §155.725)
Enrollment Processes and Periods	SHOP Enrollment periods	45 CFR §156.260; 45 CFR §155.410, 45 CFR §155.420
Enrollment Processes and Periods	Enrollee Notification	45 CFR §155.725
Enrollment Processes and Periods	Enrollment through the Exchange for Individuals	45 CFR §156.260(b), 45 CFR §156.260(e), 45 CFR §156.205(e),
Enrollment Processes and Periods	Acceptance of enrollment information	45 CFR §156.265(b)
Enrollment Processes and Periods	Premium Payment	45 CFR §156.265(c)
Enrollment Processes and Periods	Enrollment Reconciliation	45 CFR §156.265(d), 45 CFR §155.240
Enrollment Processes and Periods	Enrollment Acknowledgement	45 CFR §156.265(f); 45 CFR §155.400(d)
Enrollment Processes and Periods	Enrollment Termination	45 CFR §156.265(g); 45 CFR §155.400(b)(2)
Enrollment Processes and Periods	Termination Notification	45 CFR §155.430(b)
Enrollment Processes and Periods	Non-payment of Premium	45 CFR §156.270; 45 CFR §155.430(d)
Enrollment Processes and Periods	Notice of Non-payment of Premiums	45 CFR §156.270(c)
Enrollment Processes and Periods	Grace period for tax credit recipients	45 CFR §156.270
Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
Transparency in Coverage	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
Transparency in Coverage	Enrollee Cost Sharing	45 CFR §156.220(d)
Non-discrimination	Non-Discrimination	45 CFR §156.200(e)
Benefit Design Standards	Minimum Coverage	45 CFR §456.200(b)(3)