2024

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

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

Table of Contents

Contents

Section 1: Introduction

This Guidance for Participation specifies requirements for an issuer of a stand-alone dental plan to participate in the Washington State Health Benefit Exchange (Exchange). An issuer may participate in the Exchange by offering qualified dental plans (QDPs) that include coverage of the pediatric dental essential health benefit from November 1, 2023, through January 15, 2024, for coverage in plan year 2024. Issuers may offer family QDPs, pediatric-only QDPs, or both in the Exchange for 2024.

The Guidance will provide information on the following:

- Certifying a dental plan to become a QDP
- Monitoring and compliance of a QDP
- Decertifying a QDP
- Standards for issuers offering QDPs through the Exchange
- Expectations for issuer coordination with the Exchange
- Special guidance for coverage of American Indian/Alaska Natives

This Guidance is in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA) and Chapters 43.71 RCW and 48.43 RCW.

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

1.1 Glossary

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

ACTUARIAL VALUE

The percentage paid by a plan of the total allowed costs of benefits. Unless otherwise permitted or required by law, a stand-alone dental plan offered through the Exchange must provide a low level of coverage with an actuarial value of 70% with respect to coverage of the pediatric dental essential health benefit (EHB) or a high level of coverage with an actuarial value of 85% with respect to coverage of the pediatric dental EHB. A dental issuer may offer stand-alone plans in both actuarial value levels. A plan will be considered to meet these requirements if the actuarial value applicable to its pediatric dental EHB falls within two percentage points of 70% or 85% (45 CFR Sec.156.150(b)). Adult dental benefits included in family QDPs are not subject to these actuarial value requirements under the ACA. In addition to designating a plan as a low or high actuarial value plan, a dental issuer must limit cost sharing for pediatric dental coverage to $ 400 for one covered child and $800 for two or more covered children (45 CFR Sec.155.1065). Adult dental coverage included in family QDPs is not subject to these cost-sharing limitations.

AFFORDABLE CARE ACT

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

APPEAL

An official request from a health or dental insurance issuer that the Exchange reconsider a decision to not certify a dental plan as a QDP, deny recertification of a QDP, or decertify a QDP.

DENTAL PLAN

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

ENROLL

The point at which coverage is effective under a QDP.

ENROLLEE

Qualified individual enrolled in a QDP.

EXPIRE

The end of a plan year in which a QDP issuer elects not to seek recertification of a QDP offered through the Exchange for the following year. This act by the QDP issuer will constitute voluntary expiration of certification and result in non-certification for a subsequent consecutive certification cycle (45 CFR §156.290).

FAMILY QDP

A QDP that provides benefits for individuals of all ages and includes the pediatric dental essential health benefit.

GRACE PERIOD

Grace Period means a one-month period after an enrollee's monthly health insurance payment is due and a binding payment has been made.

HEALTH BENEFIT EXCHANGE BOARD

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

HEALTH INSURANCE ISSUER OR ISSUER

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

In this document, "issuer" refers to a dental insurance company; "product" refers to a suite of plans that share, for example, a common set of dental benefits; and "dental plan" refers to the actual insurance coverage purchased by a consumer. The document never refers to dental insurance companies as "plans" or "dental plans."

HEALTH PLAN

Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA.

A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan is the pairing of a product's benefits with a particular cost-sharing structure, provider network, and service area. Multiple health plans can be associated with a single product. A health plan that is certified by and offered through the Exchange is a Qualified Health Plan (QHP).

QHPs offered on the individual Exchange will not include embedded dental benefits.

IMMIGRANT HEALTH COVERAGE PROGRAM

In 2021, the Washington State Legislature directed the Exchange to explore access pathways for Washington residents who do not currently qualify for state or federal coverage options. The Legislature authorized the Exchange to seek a federal Section 1332 waiver for this purpose and required a state-based solution to be implemented by no later than plan year 2024. In December 2022, CMS approved

Washington's 1332 waiver that allows all Washington residents, regardless of immigration status, to enroll in health and dental coverage through *Washington Healthplanfinder* beginning in plan year 2024.

NAVIGATOR

An organization that has been awarded a contract 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 and QDP or Washington Apple Health (Medicaid) by a consumer for *Washington Healthplanfinder*.

OPEN ENROLLMENT PERIOD

The period each year during which consumers may enroll or change coverage in a QHP and QDP through *Washington Healthplanfinder*. The open enrollment period for the 2023 plan year is from November 1, 2023, through January 15, 2024, unless otherwise published by the Exchange as an amendment to the 2024 QDP Guidance for Participation.

PEDIATRIC-ONLY QDP

A QDP that provides benefits for individuals ages 0 up to 19 only and includes the pediatric dental essential health benefit. Individuals turning 19 during a plan year are entitled to maintain their enrollment in their pediatric-only QDP for the remainder of the plan year.

PLAN YEAR

The consecutive 12-month period during which a health or dental plan provides coverage for health or dental benefits. For individuals, it is the calendar year.

PRODUCER

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

QUALIFIED DENTAL PLAN OR QDP

A stand-alone dental plan (as required under RCW 43.71.065(2)) that is certified by the Exchange after being determined to meet the criteria described in Section 2 below, and is a commitment to insure at a minimum the essential health benefit of pediatric oral services (established as an essential health benefit under ACA § 1302(b) and defined under WAC 284-43-5700) under specific cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

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

SPECIAL ENROLLMENT PERIOD

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

WASHINGTON HEALTHPLANFINDER OR HEALTHPLANFINDER

The marketplace in Washington State operated by the Washington Health Benefit Exchange where qualified individuals can shop for and purchase Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs).

1.2 Overview of Guidance

1.2.1 OBJECTIVE

The purpose of this Guidance is to provide dental plan issuers the foundational information needed to offer QDPs through the Exchange. The certification criteria set forth within this document do not supersede a QDP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some federal and state laws or regulations that apply to offering dental coverage through the Exchange, a QDP issuer is required to comply with all relevant state and federal laws in order to offer coverage through the Exchange.

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

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

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

1.2.2 TERM OF ENGAGEMENT

New or renewed family dental plans, certified or recertified as a QDP, will be available for preview prior to the start of open enrollment for a period as determined by the Exchange. New and renewed plans will be available for selection beginning November 1, 2023, with an initial effective date of coverage beginning no earlier than January 1, 2024.

Dental issuers responding to this Guidance may offer certified or recertified QDPs for a term of one year beginning January 1, 2024, and ending December 31, 2024. Only OIC-approved stand-alone family or pediatric dental plans certified by the Board may be offered as QDPs through the Exchange during this period.

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

1.2.3 CONTACT

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

For questions about OIC regulatory requirements referenced throughout this document, please contact the OIC Rates and Forms HelpDesk at (360) 725-7111.

1.2.4 PLAN CERTIFICATION TIMELINE AND LETTER OF INTENT

An issuer is recommended to inform the Exchange of its intent to participate in the Exchange by submitting a letter of intent. Submitting a letter of intent is not mandatory and is nonbinding, but will help the Exchange communicate with potential participating issuers and prepare for the certification process. The letter of intent should be in letter format on official letterhead and signed by the issuer's Chief Executive Officer or their designee. The due date for the letter of intent is specified in the plan certification timeline. Issuers should include a list of counties in which they intend to offer coverage and to specify, what, if any, service area changes they are anticipating (e.g., entering or leaving a county). The letter of intent is for internal Exchange use only and will not be shared publicly. An issuer may submit a letter of intent at QHP@wahbexchange.org.

PLAN CERTIFICATION TIMELINE

The Exchange expects issuers to adhere to the plan certification timeline. Please click on the following link to find the 2024 plan certification timeline: Linked here (to be updated later).

1.3 Participating in the Exchange

A QDP issuer may participate in the Exchange's individual market. Chapter 43.71 RCW specifies that the Exchange will offer only stand-alone dental plans.

1.3.1 INITIAL CERTIFICATION OF QUALIFIED DENTAL PLANS

The Exchange certifies QDPs annually. Only those dental plans certified or recertified by the Exchange may be offered as QDPs through the Exchange.

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

An issuer must enter into a Participation Agreement with the Exchange before offering QDPs through the Exchange. The Participation Agreement requires issuers to adhere to the stand-alone dental plan certification criteria described in this Guidance. The Exchange, in addition to the Legislature and OIC, reserves discretion to modify and amend the terms and conditions of current QDP certification criteria and how they may be applied in the certification or decertification process, consistent with current laws and rules, at any time, including after the execution of issuer Participation Agreements.

Prior to publishing plan offerings, an issuer must also enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and one or more EDI interfaces will need to be tested between the issuer and the Exchange. These steps will ensure that the issuer and the Exchange will be able to communicate enrollment data.

Issuers who rely primarily on third-party vendors for communication of enrollment data are expected to coordinate with the Exchange when there is a change in vendors. Issuers are responsible for ensuring their vendors conform to the EDI Trading Partner Agreement.

1.3.2 RECERTIFICATION OF QUALIFIED DENTAL PLANS

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

1.3.3 SUBMITTING A DENTAL PLAN TO BECOME CERTIFIED AS A QDP

The Exchange certification process begins when an issuer submits rate, form, SERFF Binder, and network filings to OIC for regulatory review and approval. All stand-alone plans submitted for certification by the Exchange must include the pediatric dental EHB. All dental plans submitted for certification by the Exchange to be offered in the Exchange must apply a rating structure based on age bands and use the single rating area of Washington State. (These rating structure and rating area requirements do not apply to stand-alone dental plans seeking QDP certification that are to be offered only outside the Exchange.)

Please contact OIC for information on when, how, and where to submit the filing documents for a stand-alone dental plan. Issuers shall submit to the Exchange the QDP submission form provided by the Exchange at the time of filing.

The Exchange intends to complete the certification or recertification process for 2024 plans by September 15, 2023. Issuers should have received OIC approval of any plans for which they are seeking Exchange certification by September 8, 2023, to guarantee consideration for certification for 2023. If an issuer wishes to withdraw a plan from consideration for QDP certification after plan approval by OIC, the issuer must submit a plan withdrawal form to the Exchange.

Plans certified by September 15, 2023, will be included in the Exchange's plan preview period and auto-renewals for the 2024 plan year, and will be available through the Exchange in open enrollment for 2024 coverage. Any plans certified after September 15, 2023, may be considered for inclusion on a case-by-case basis.

Section 2: Specifications for Participation

2.1 Summary Table 1: Initial Certification and Recertification Criteria

To participate in the Exchange's QDP certification process, an issuer must submit plans and supporting documentation as specified for each criterion. The following table summarizes the ten criteria applied in the certification process of a QDP. Each criterion is reviewed and approved by either OIC or the Exchange..

No.	Criteria Level	Criteria	OIC or Exchange Review	Initial Certification Criteria	Recertification Criteria
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QDPs assessed	Exchange	Yes	Yes
3	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
4	Product	QDP must meet marketing requirements	Exchange	Yes	Yes
5	Product	QDP must meet network access requirements, including essential community providers	OIC	Yes	Yes
6	Product	Issuer must display or submit dental provider directory data	Exchange	Yes	Yes
7	Product	Issuer must submit dental plan data to be used in a standard format for presenting dental benefit plans options	Exchange	Yes	Yes
8	Plan	A QDP must comply with benefit design standards (e.g., cost sharing limits, actuarial value requirements, essential health benefits designated for stand-alone dental plans)	OIC	Yes	Yes
9	Plan	Issuer must submit a QDP's service area and rates for a plan year	OIC	Yes	Yes
10	Plan	Issuer must submit QDP benefit and rate data for public disclosure	Exchange	Yes	Yes

In addition to dental plans that will be offered in the Exchange, the Exchange Board is required to consider stand-alone dental plans that are submitted to be offered only in the outside-Exchange individual and small group markets for certification as QDPs (WAC 284-43-879). These plans are only required to comply with the criteria above that are reviewed by the OIC. An issuer seeking certification for a stand-alone dental plan to be offered only outside the Exchange must notify the Exchange when such a dental plan is filed with OIC and when any such plan receives OIC approval.

2.2 QDP Specifications

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

2.2.1 LICENSED AND GOOD STANDING

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

OIC determines if an issuer is in good standing. Please direct requests for a certificate of good standing to companysupervisionfilings@oic.wa.gov.

OIC determinations of good standing will be based on authority granted to 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 should inform the Exchange immediately, but in any case within two business days, if OIC has restricted in any way the issuer's authority to write any of its authorized lines of business. If OIC has restricted the issuer's ability to underwrite current or new health or dental plans, the Exchange will determine, consistent with OIC restrictions, if the issuer can submit a stand-alone dental plan for certification or recertification as a QDP.

Restrictions on an issuer's ability to underwrite current or new dental plans may result in QDP decertification by the Exchange.

2.2.2 USER FEE ADHERENCE

RCW 43.71.080 designates a portion of premium tax receipts and fees assessed on QHPs and QDPs as funding for the Exchange's operating expenses. Pediatric-only QDPs are subject to the premium tax and an Exchange assessment, and family QDPs are subject to the premium tax and a separate Exchange assessment.

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

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

2.2.3 NON-DISCRIMINATION

A QDP issuer must comply with federal and Washington State nondiscrimination requirements. A QDP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.125 and §156.200(e)), or on the basis of an individual's degree of medical dependency, health status of condition, quality of life, or expected length of life (ACA Sec. 1302(b)(4)(D)).

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

2.2.4 MARKETING

A QDP issuer is encouraged to actively market products available through *Washington Healthplanfinder* and to participate in joint marketing efforts with the Exchange, as applicable. The Exchange has created its own logo that designates the certification of a QDP. Carriers that offer products certified as QDPs give the Exchange the right to use their logos in the Exchange application and acknowledge that Exchange-designated logos are included in QDPs displayed through the Exchange. The QDP issuer will be provided any Exchange marketing materials, for review, that use the QDP issuer's logo. Issuers are required to provide the Exchange information about their communication and advertising plans at least one month in advance of implementation. This information should be provided to the Exchange Chief Marketing Officer and Associate Director of Marketing through email.

An issuer can use Washington Healthplanfinder logos to co-brand QDP marketing materials or web pages in accordance with guidelines developed by the Exchange Communications. The Exchange Style Guide, linked here, can be found on the corporate website (wahbexchange.org) under Partner Toolkit. The logos cannot be modified, and no other logo can be used to represent Washington Healthplanfinder or QDP certification. The Exchange must review and approve any use of Exchange brands and logos on an issuer's marketing materials. Approval should be requested by sending an email to QHP@wahbexchange.org.

Issuers should provide the Exchange with a marketing brochure for each QDP in English and Spanish for display on *Washington Healthplanfinder*. Carriers are encouraged to have unique marketing materials for each product offered. These documents should be submitted to the Exchange via email in PDF format. The due date for providing marketing materials is specified in the plan certification timeline.

The QDP issuer cannot inform consumers that the certification of a QDP implies any form of further endorsement or support of the QDP. A QDP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that may discourage the enrollment of individuals with preexisting conditions or significant health needs in QDPs (45 CFR §156.225(b)).

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

2.2.5 NETWORK ACCESS

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

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

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

An issuer shall notify the Exchange in writing, in addition to OIC, when notification of network changes is required under WAC 284-170-230. Issuers should notify the Exchange of network changes described in WAC 284-170-230 that will be occurring from one plan year to the next by September 15 (or, if later, as soon as possible after the issuer becomes aware of the anticipated change).

2.2.6 PROVIDER DIRECTORY

QDP issuers must provide data on the dental providers that participate in networks associated with their QDPs sold on the Exchange.

Pediatric-only QDP issuers are required to display accurate and complete dental provider directory data associated with their pediatric-only QDPs sold on the Exchange on their websites and update that data by the first day of each month.

Family QDP issuers must update their dental provider directory data associated with their family QDPs sold on the Exchange with the Exchange, and any vendor utilized by the Exchange to support the provider directory, on or by the 15th of each month, unless otherwise instructed. If the 15th falls on a weekend or holiday, provider directory data is due by midnight the business day prior.

For the provider directory data to be used for the start of open enrollment, issuers must include providers for the current and upcoming plan years. Provider rosters for the 2024 plan year should be submitted to the Exchange by issuers of family QDPs for the first time in a stand-alone submission due by September 15, 2023. For the duration of the 2023 plan year, provider rosters for both the 2023 and 2024 plan years will be included in the issuer data submissions due the 15th of each month. Issuers of family QDPs should identify the appropriate plan year associated with each provider roster file. If there is no network variance across plan years, issuers may submit a single roster file. At the conclusion of the 2023 plan year, the 2023 roster submission is no longer necessary and must be discontinued.

On-time submissions are processed and published to *Washington Healthplanfinder* the following month. A QDP issuer must ensure that the network name for each provider exactly matches the network name as approved by OIC. Issuers are responsible for conducting quality assurance of provider directory data prior to submission and are expected to participate in ongoing provider directory testing and coordination activities.

The Exchange's provider directory vendor, conducts ongoing provider outreach to validate provider data with the goal of improving provider directory data for the Exchange. Weekly error reports are generated by the provider directory vendor and based on provider attestation. In addition, the Exchange identifies provider errors during testing, from OIC, from consumers, from providers, and through the Provider Directory Comment Form, available on the Exchange website. Issuers should review weekly error reports provided by the provider directory vendor and errors escalated by the Exchange and correct erroneous data in their systems in a timely manner. Issuers shall submit a corrected provider roster the following month to resolve any discrepancies.

If a discrepancy is not pertinent to the issuer, or the issuer does not agree with the findings, the issuer should address the discrepancy with the provider directory vendor or the Exchange, depending on who identifies the discrepancy, and discrepancies should be resolved between the two parties. If the provider directory vendor and the issuer cannot come to a resolution, the discrepancy should be elevated to the Exchange for further review. The Exchange will continue efforts to improve provider directory data. Issuers will be consulted to establish next steps regarding reducing data discrepancies.

2.2.7 STANDARD FORMAT FOR PRESENTING DENTAL BENEFIT PLAN OPTIONS

Issuers are required to provide the Exchange with a Summary of Benefits and Coverage (SBC) for each QDP, in English and Spanish, for display on *Washington Healthplanfinder*. Dental plans should submit their SBC documents to the Exchange by the date specified in the plan certification timeline. If plan benefits change following submission of SBC documents, issuers must make any necessary changes within five business days and submit updated documents to the Exchange. A standard SBC form for dental plans will be published by the Exchange annually.

The Exchange will review submitted SBCs for completeness and provide feedback to issuers. Issuers should respond to feedback by incorporating feedback or providing a response as to why feedback may not be incorporated. Issuers may choose to wait for feedback prior to submitting Spanish language SBCs.

Issuers will submit SBCs to the Exchange via email in PDF format. One compressed/zip folder will contain information for each plan. The name of the folder will be the HIOS Plan ID. Each SBC file will be named as follows:

- Full Plan Name
- Pediatric-only or family indicator
- Actuarial value of high or low
- English or Spanish

Sample:

- Zip Folder: 12345WA0020001
    - File Name: ExcellentCareFamilyLowEnglish
    - File Name: ExcellentCareFamilyLowSpanish

2.2.8 BENEFIT DESIGN STANDARDS

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

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

In addition to designating a plan as a low or high actuarial value plan, a dental issuer must limit cost sharing for pediatric dental coverage to $400 for one covered child and $800 for two or more covered children (45 CFR § 156.150). Adult dental coverage included in family QDPs is not subject to these cost-sharing limitations under the ACA.

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

2.2.9 SERVICE AREAS AND RATING REQUIREMENTS

The QDP service area must be established without regard to racial, ethnic, language, or health-status related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). QDP service areas will generally be set by county and consumers will be able to identify a service area by providing a zip code and county in *Washington Healthplanfinder*.

The Exchange will display QDP rates on the *Washington Healthplanfinder* web pages. A QDP issuer's dental plan rates are for an entire plan year. Approval of a plan by OIC will confirm that a QDP has met the service area standards.

All stand-alone dental plans submitted for certification by the Exchange to be offered in the Exchange must apply a rating structure based on age bands and use the single rating area of Washington State.

The total premium is determined by summing the rate of each enrollee covered by the QDP. For QDPs with multiple enrollees under the age of 21, the per-member rate for no more than the three oldest covered children must be used in determining the total QDP premium.

2.2.10 REPORTING DATA

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

The Exchange will use these templates to populate *Washington Healthplanfinder* with rates, benefits, service area, and provider network names. The Exchange will not alter the data within these templates without written direction from OIC. Issuers are required to review these data during the annual ratification process (the validation of plan data in *Washington Healthplanfinder*) to ensure the accuracy of the information. The Exchange reserves the right to charge an issuer for incurred costs if the issuer requests changes to plan data after the issuer has reviewed and ratified that plan data. Before charging for incurred costs, the Exchange will take into consideration the circumstances of the request to make changes to plan data.

Issuers offering QDPs through the Exchange must provide data in a manner and frequency specified by the Exchange as necessary to support Exchange operations, including but not limited to:

- Eligibility, enrollment, or disenrollment processes;
- Reports or provision of information required by the U.S. Department of Health and Human Services, Internal Revenue Service, or the Washington State Legislature; and
- Estimation or collection of assessments or fees specified in RCW 43.71.080.

2.3 Monitoring and Compliance of Qualified Dental Plans

2.3.1 SUMMARY TABLE 2: MONITORING AND COMPLIANCE OF QUALIFIED DENTAL PLANS

The following chart summarizes the monitoring and compliance activities associated with the ten certification criteria. Monitoring activities are conducted by either OIC or the Exchange. Any penalties associated with criteria #2 and #4 were described in the previous section. See sections 2.1 and 2.2 for further detail on the certification criteria.

No.	Criteria Level	Criteria	Monitoring Entity	Exchange Penalty	Decertification Criteria
1	Issuer	Issuer must be in good standing	OIC	N/A	Yes
2	Issuer	Issuer must pay user fees, if QDPs assessed	Exchange	Yes (see Section 2.2.2)	Yes
3	Issuer	Issuer must comply with non-discrimination rules	OIC	N/A	Yes
4	Product	QDP must meet marketing requirements	Exchange	Yes (see Section 2.2.4)	No
5	Product	QDP must meet network access requirements which will include essential community providers	OIC	N/A	Yes
6	Product	Issuer must display or submit dental provider directory data	Exchange	No	Yes
7	Product	Issuer must submit dental plan data to be used in a standard format for presenting dental benefit plans options	Exchange	No	No
8	Plan	A QDP must comply with benefit design standards (e.g., cost sharing limits, AV requirements, EHBs designated for stand-alone dental plans)	OIC	N/A	Yes
9	Plan	Issuer must submit to WAHBE a QDP's service area and rates for a plan year	OIC	N/A	Yes
10	Plan	Issuer must submit QDP benefit and rate data for public disclosure	Exchange	No	No

2.4 QDP Status Changes

2.4.1 CHANGES TO PLANS AS PART OF THE ANNUAL CERTIFICATION PROCESS

The Exchange certification of a QDP lasts for one plan year and must be renewed for each future plan year in which the issuer seeks to offer the QHP in the Exchange, as set forth in 45 CFR §156.290 and 45 CFR §155.1080. During the annual plan filing and certification process, a QDP issuer may elect not to seek Exchange recertification of a QDP and may discontinue the plan at the end of the year. A QDP issuer must notify the Exchange of any QDPs for which it intends to seek certification or recertification upon filing the plan with OIC. An issuer must fulfill the obligations set forth in 45 CFR §156.290 with respect to any QDP that will be discontinued at the end of a plan year, including providing coverage until the end of the plan year and providing the required 90-day discontinuation notice to enrollees. During the Exchange's automated renewal process in open enrollment, the Exchange will cross-map enrollees, in accordance with 45 CFR §155.335, and other applicable regulations.

If a QDP issuer exits the individual market entirely, it must provide written notice to the Exchange that all of the issuer's QDPs will be discontinued at least 180 days before the date the coverage will expire. The QDP issuer must also provide formal 180-day notice to enrollees as required in RCW 48.43.038. The QDP issuer must terminate coverage for the enrollees, as set forth in 45 CFR §156.270, only after the enrollees have had an opportunity to participate in open enrollment as set forth in 45 CFR §156.290.

2.5.2 DENIAL OF RECERTIFICATION

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

2.5.3 CHANGES TO PLANS AFTER CERTIFICATION

The Exchange reserves the right to recoup from an issuer costs incurred by the Exchange resulting from the withdrawal of a plan from being offered in the Exchange after the QDP certification process is completed and plan data has been loaded into Exchange systems and ratified by issuers.

2.5.4 CHANGES TO PLANS DURING A PLAN YEAR

Decertification of a QDP could occur in the middle of a plan year if OIC withdraws regulatory approval or if the Exchange determines that a QDP no longer satisfies certification criteria. The Exchange will decertify QDPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080. QDP issuers must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after the Exchange has notified enrollees and the enrollees have had an opportunity to participate in special or open enrollment as outlined in 45 CFR §155.1080. If the plan is decertified by the Exchange but maintains OIC regulatory approval, the plan shall be made available outside of the Exchange for any current enrollees.

If a QDP issuer petitions OIC to suspend new sales for the individual market, the QDP issuer must notify the Exchange of the petition and subsequent OIC action on the petition for suspension within two

business days of OIC's decision. The QDP issuer must enroll any new enrollees who have selected a plan up through the date of suspension, including those with effective dates after the date of suspension. The Exchange will not offer a suspended QDP to new enrollees for the following year's coverage during open enrollment. A suspended QDP must continue to provide special enrollment to its current enrollees with qualifying events but will not participate in special enrollment when enrollees of other QDPs or new enrollees experience qualifying events. To be offered through *Washington Healthplanfinder*, a suspended QDP must continue to achieve annual recertification.

Section 3: Enrollment in a QDP

3.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the Exchange Enrollment and Payment Process Guide and EDI standards contained in the 834 Companion Guide. The Enrollment and Payment Process Guide and 834 Companion Guide can be obtained on the Exchange website.

A QDP issuer must agree to comply with policies, standards, and processes established by the Exchange for transfer of EDI transactions, enrollment, reconciliation, and reporting. This includes accepting all required forms of payment, managing grace periods, participating in process improvement initiatives with the Exchange (e.g., the fitgap initiative and enhancements to the monthly reconciliation process), and adhering to sponsorship program requirements established in RCW 43.71.030 and the Exchange Sponsorship Policy available on the Exchange website (e.g., accepting payments on behalf of individuals from Exchange-registered sponsors; issuing refunds to Exchange-registered sponsors; providing a sponsor with an accounting of the total amount owed to the issuer).

As required by 45 CFR 156.115(a)(6), pediatric services required under 45 CFR 156.110(a)(10) are to be provided for enrollees up to age 19. Issuers offering pediatric QDP coverage through the Exchange shall not disenroll such individuals from a pediatric QDP due to attaining age 19 until the end of the plan year in which the individual attains the age of 19. These individuals will not be eligible for renewal into their pediatric QDP and the Exchange will not auto-renew them into a pediatric QDP for the plan year following the year they turn 19.

Issuers making dependent coverage of children available through the Exchange shall not disenroll such individuals from a parent's plan due to attaining age 26 until the end of the plan year in which the individual attains the age of 26. These individuals will not be eligible for renewal into their parent's QDP and the Exchange will not auto-renew them into the parent's QDP for the plan year following the year they turn 26.

If enrollment discrepancies are not resolved within three months from the first occurrence of the error on the monthly Full Carrier Audit (FCA), carriers are not permitted to hold customers financially responsible if correction of the error results in them having been previously under-billed.

3.1.1 PLAN MAPPING

The Exchange performs plan mapping to facilitate renewals during the annual open enrollment period, to help consumers avoid breaks in coverage, and to help customers navigate the complex plan selection process. The Exchange engages in plan mapping pursuant to authority under federal regulations, requirements under federal and state law, and in consultation with the OIC.

All issuers that offer QDP coverage through the Exchange during 2023 and 2024 must perform mapping for plan year 2024 in accordance with applicable state law and federal requirements. Issuers must cross-map all prior year non-renewing QDPs to another QDP available in the same county for the subsequent year, if available. The Exchange will review each carrier's cross-mapping assignments for compliance with applicable law, including federal requirements set forth in 45 CFR 155.335, state law, and OIC and Exchange guidance. The Exchange may cross-map enrollees from one issuer to another, and may identify certain enrollees to be mapped in special circumstances as permitted by applicable law and in accordance with OIC guidance.

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

3.1.2 FILE TRANSFER AND PAYMENT DUE DATES

For 2024 enrollments, QDP issuers are expected to comply with the following due dates for initial payments and effectuation, cancellation, and termination files:

Effectuation during Open Enrollment

- Binder payment due date must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.
- An effectuation or cancellation transaction is due to the Exchange within 10 business days of binder payment due date. If a carrier offers a binding payment extension, the carrier-generated effectuation or transaction is due to the Exchange within 10 business days of the binder payment extension end date.

Effectuation during Special Enrollment

Binder payment:

- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

If issuer does not verify the qualifying event:

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

If issuer does verify the qualifying event:

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

Rescission due to failure to prove special enrollment qualifying event:

- During special enrollment, issuers may rescind an enrollee's coverage if the documentation provided to an issuer does not support the qualifying event. Cancellations of coverage due to failure to provide documentation to support the qualifying event shall be communicated to the Exchange via the manual reconciliation process (i.e., issuers will not transmit an 834 transaction).

Termination for Nonpayment

All individuals enrolled in a QDP, regardless of application of APTC toward a QHP enrollment, are eligible for a one-month grace period for late payment toward their QDP. A termination for nonpayment transaction is due to the Exchange within 10 business days of expiration of one-month grace period.

Carriers may not condition renewal during an open enrollment period on payment of outstanding premiums owed. Customers will be automatically renewed into 2024 coverage if otherwise eligible, or may actively enroll into 2024 coverage regardless of the disposition of any past due premium.

More information can be found in the Exchange Enrollment and Payment Process Guide.

Premium Payment Threshold

Issuers may be required to provide a report to the Exchange describing their use of a premium payment threshold as described under 45 CFR § 155.400(g) with respect to Exchange enrollees' premium payments. Issuers must report their anticipated use of a premium payment threshold for plan year 2024 to the Exchange by October 1, 2023, by providing notification to QHP@wahbexchange.org.

3.1.3 CO-PAY ACCUMULATOR POLICIES

Issuers with co-pay accumulator policies that define how consumer out-of-pocket spending accumulates toward the deductible and out-of-pocket maximum will be required to meet the following requirements:

- Provide notice in the Summary of Benefits and Coverage by indicating which benefits are subject to such policies in the "Limitations, Exceptions, and Other Important Information" column.
- Payments made on behalf of consumers by a charitable organization, tribe, government entity, or other sponsor organization through the Exchange's sponsorship policy must accumulate toward the consumer's deductible if they would have accumulated toward the deductible had a consumer made the payment directly.
- When an enrollee changes plans during a plan year and retains coverage with the same issuer without a break in coverage, the issuer is expected to apply any amounts previously paid toward

the enrollee's deductible and out-of-pocket maximum in the first plan toward the enrollee's deductible and out-of-pocket maximum in the second plan.

3.2 Producer and Navigator Specifications

3.2.1 PRODUCER

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

If an issuer has knowledge of producer noncompliance with applicable agent and broker conduct standards of 45 CFR 155 Subpart C, issuer shall notify the Exchange as soon as possible.

If an issuer terminates a producer from an issuer appointment agreement, the issuer shall notify the Exchange as soon as possible.

Please refer to OIC for more information on producer licensing requirements.

3.2.2 NAVIGATOR

The Exchange will award contracts to organizations to deliver in-person application and enrollment assistance that meets the standards described in 45 CFR §155.210. Certified assisters will be trained to engage in education, outreach, and enrollment related to *Washington Healthplanfinder*. The navigator program primarily focuses on outreach and assistance to populations that experience barriers to enrolling and accessing health care coverage. Navigators must meet security, confidentiality, and conflict of interest standards and are prohibited from receiving indirect or direct compensation from a health or dental insurance issuer based on enrollment. Health or dental insurance issuers cannot act as Navigators.

3.3 Complaints

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

Section 4: Special Guidance for Coverage of American Indian/Alaska Natives (AI/AN)

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

- A once-a-month enrollment period to enroll or change plans in *Washington Healthplanfinder* for any AI/AN individual enrolled in a federally recognized tribe or Canadian Indian lawfully present in the U.S. under the Jay Treaty;

- No cost sharing for any item or service furnished through Indian Health Care Providers, as defined in Section 1402(d)(2) of the ACA;

- Health programs operated by Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,

- Compliance with Indian Health Care Improvement Act § 206 and § 408.

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

Issuers are strongly recommended to adapt the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Care Providers for use with a stand-alone dental plan and include it when contracting with an Indian Health Care Provider.

A QDP issuer must adhere to sponsorship program requirements as referenced in Section 3.1 above, including accepting payments from and issuing refunds to Exchange-registered tribal sponsors.

Section 5: Issuer Certification Appeal Process

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

An issuer will have up to 10 calendar days from the date of the notification of a Board decision to deny initial certification of a stand-alone dental plan, deny recertification of a QDP, or decertify a QDP, to submit a written appeal via electronic mail to the General Counsel of the Exchange.

An issuer's appeal must:

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

After submitting the appeal:

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

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