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Title: 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges¹

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges (2024 Draft Letter). This 2024 Draft Letter provides updates on operational and technical guidance for the 2024 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFE) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of this 2024 Draft Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2024. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2024 Draft Letter focuses on guidance that has been updated for the 2024 plan year, and refers issuers to the 2017 through 2023 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.² CMS notes that the policies articulated in

¹ The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

² See Center for Consumer Information and Insurance Oversight, CMS, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016), available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers_022916.pdf; Center for Consumer Information and Insurance Oversight, CMS, Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 17, 2017), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>; Center for Consumer Information and Insurance Oversight, CMS, 2019 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 9, 2018), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf>; Center for Consumer Information and Insurance Oversight, CMS, 2020 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 18, 2019), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2021 Letter to Issuers in the Federally-facilitated Marketplaces (May 7, 2020), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2022 Letter to Issuers in the Federally-facilitated Marketplaces (May 6, 2021), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2023 Letter to Issuers in the Federally-facilitated Marketplaces (April 28, 2022), available at:

this 2024 Draft Letter apply to the QHP certification process for plan years beginning in 2024.³ Throughout this 2024 Draft Letter, CMS identifies the areas in which states performing plan management functions in the FFEs have flexibility to follow an approach different from that articulated in this guidance.

Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics are set out in Title 45 of the Code of Federal Regulations (CFR) Subtitle A, Subchapter B. Unless otherwise indicated, regulatory references in this 2024 Draft Letter are to Title 45 of the CFR.⁴ While certain parts of the 2024 Draft Letter explain associated regulatory requirements, the 2024 Draft Letter is not a complete list of regulatory requirements for issuers.

CMS welcomes comments on this proposed guidance. To the extent this guidance summarizes policies proposed through other rulemaking processes that have not yet been finalized, such as the rulemaking process for the proposed 2024 Payment Notice,⁵ stakeholders should comment on those underlying policies through the ongoing rulemaking processes, and not through the comment process for this Letter. Please send comments on other aspects of this 2024 Draft Letter to PMpolicy@cms.hhs.gov by January 12, 2023. Comments will be most helpful if organized by the subsections of this 2024 Draft Letter.

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf>.

³ Plan years in the FF-SHOPs will not always align with calendar year 2024.

⁴ Available at: <https://ecfr.federalregister.gov/current/title-45>.

⁵ Refer to the proposed 2024 Payment Notice, which went on display on December 12, 2022, for further details.

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CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

(This chapter relies on authority from Affordable Care Act (ACA) sections 1311(c) and (e) and 1321(a); and 45 CFR 147.106, Part 150, Part 155 Subpart K, 155.335(j), 156.200, 156.272, and 156.290.)

The ACA and applicable regulations provide that health plans, including SADPs, must meet a number of standards in order to be certified as QHPs. Several of these are market-wide standards that apply to plans offered in the individual and small group (including merged) markets, both inside and outside of the Exchanges. The remaining standards are specific to health plans seeking QHP certification from the Exchanges.

This chapter provides an overview of the QHP certification process. This process applies to all states in which an FFE operates, which include (1) states performing plan management functions and making QHP certification recommendations to CMS, (2) states where CMS is performing all plan management functions and certifying QHPs while the state is enforcing the insurance market reforms in the Public Health Service (PHS) Act, and (3) states where CMS is performing all plan management functions and where the state does not enforce insurance market reforms added to the Public Health Service Act by the ACA,⁶ or by Titles I and II (the No Surprises Act and Transparency Act) of Division BB of the Consolidated Appropriations Act, 2021.⁷ Additional information and instructions about the process for issuers to complete a QHP application can be found at <https://www.qhpcertification.cms.gov>.

Section 1. QHP Certification Process

CMS expects issuers and state regulatory authorities in states with Exchanges using the federal platform applying for QHP Certification to adhere to the plan year 2024 QHP Data Submission Timeline.⁸

Issuers will submit a complete QHP application for plans they intend to have certified in a state in which an FFE is operating. CMS will review QHP applications for all issuers applying for QHP certification in an FFE⁹ and notify issuers of any need for corrections. After the final QHP application submission deadline, issuers may be required to submit corrected final QHP data during a limited data correction window to address CMS or state-identified errors.

⁶ The list of states that do not enforce the ACA market wide-requirements is available at:

<https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/compliance.html>.

⁷ SBE-FPs retain the authority and primary responsibility for the certification of QHPs and should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this Final Letter.

⁸ Refer to the forthcoming guidance from the Proposed Plan Year 2024 QHP Data Submission Timeline for further details.

⁹ In accordance with 45 CFR Part 155 Subpart K, CMS will review, and approve or deny, QHP applications from issuers that are applying to offer QHPs in the FFEs. CMS will not conduct QHP certification reviews of plans that are submitted for offering only outside of the FFEs, except for SADPs seeking off-Exchange certification. In the case of an FF-SHOP QHP certification, except when the QHP is decertified pursuant to 45 CFR 155.1080, the QHP certification remains in effect through the end of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified. FFEs will not display ancillary insurance products and health plans that are not QHPs (e.g., stand-alone vision plans, disability, or life insurance products). The FFEs will only offer QHPs, including SADPs.

If an issuer wishes to withdraw a plan from consideration in the QHP Certification process, or to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration, the issuer must follow the plan withdrawal process provided by CMS. An issuer's final plan confirmation to CMS is generally the last opportunity for the issuer to withdraw a plan from certification consideration for the upcoming plan year.

After correcting plan data and finalizing the list of plans offered for certification, issuers intending to offer QHPs, including SADPs, in a state in which an FFE is operating, including states performing plan management functions, will sign and submit to CMS a QHP Certification Agreement and Privacy and Security Agreement (the "QHP Certification Agreement") and a Senior Officer Acknowledgement.¹⁰ CMS will sign the QHP Certification Agreement and return it to issuers along with a final list of certified QHPs, completing the certification process for the upcoming plan year. After receiving the QHP Certification Agreement signed by CMS, issuers may begin marketing their plans as certified QHPs and providing information about the plans to FFE-registered agents and brokers.

Issuers may have their QHP application denied if they fail to meet the deadlines in the plan year 2024 QHP Data Submission Timeline, or if their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.¹¹

Section 2. QHP Application Data Submission

CMS requires issuers, including SADP issuers, to submit complete QHP applications by the initial submission deadline in the plan year 2024 QHP Data Submission Timeline and to make necessary updates to the QHP application before the last deadline for issuer submission. Additionally, issuers must comply with any CMS requirements related to rate filings. There are certain states where CMS is directly performing rate review as well as enforcing other applicable PHS Act requirements.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.¹² All issuers must also register for the PM Community to receive relevant

¹⁰ The documents will apply to all QHPs offered by a single issuer in an FFE at the HIOS Issuer ID level or designee company. Issuers should ensure that the legal entity information listed in HIOS under the Issuer General Information section is identical to the legal entity information that will be used when executing the documents.

¹¹ Regulations at 45 CFR 155.1000 provide Exchanges with broad discretion to certify QHPs that otherwise meet the QHP certification standards specified in Part 156, and afford Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the "interest" of qualified individuals and qualified employers.

¹² See additional information on HIOS registration, which is contained in the HIOS Portal User Manual. The HIOS Portal User Manual is available at: <https://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index.html#Content%20Requirements%20for%20Plan%20Finder>. CMS expects issuers to use the same HIOS plan identification numbers for plans, including SADPs, submitted for certification for the 2024 plan year that are the same as plans, including SADPs, certified as QHPs for the 2023 plan year, as defined in 45 CFR 144.103 and pursuant to 45 CFR 147.106. While 45 CFR 147.106 is not applicable to issuers of SADPs, CMS expects that SADP issuers' HIOS plan identification numbers will be the same for the 2024 plan year if the plan has not changed since the SADP was certified for the 2023 plan year, even if the plan has been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value. The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to 45 CFR 155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for the 2024 plan year that had been certified for the 2023 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

communications regarding their QHP applications.¹³

Issuers applying for QHP certification in FFEs, excluding those in states performing plan management functions, must submit their QHP applications in HIOS.¹⁴ Issuers in states performing plan management functions should submit QHP applications in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF) in accordance with state and CMS review deadlines. Issuers submitting applications for QHP Certification in SERFF should work directly with the state to submit all QHP issuer application data in accordance with state guidance.¹⁵

All issuers applying for QHP certification for PY24 will receive feedback on whether their data passes validations at the point of submission as well as after the data are fully submitted to CMS. CMS encourages applicants to access the Plan Preview module of HIOS to review plan data, verify that their plan display reflects their state-approved filings, and identify and correct data errors before the QHP application data submission deadline. Issuers can use Plan Preview to check their plan benefit data display for most enrollment scenarios, including service areas, cost sharing for benefits, and URLs, including payment redirect.

CMS encourages issuers to review the data in Plan Preview throughout the QHP certification process to ensure that the plan benefit data are correct. Discrepancies between an issuer's QHP application and approved state filings may result in a plan not being certified. If CMS has already certified a plan as a QHP, the plan may be decertified or subject to appropriate compliance or enforcement action.

Section 3. QHP Data Changes

CMS will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that CMS identifies during its review of QHP applications.

Table 1.1 outlines the parameters under which issuers may change their submitted QHP data. Issuers may make changes to their QHP applications without state or CMS authorization until the deadline for initial application submission. After the close of the initial QHP application submission window, issuers may not add new plans to a QHP application or change an off-Exchange plan to be both on and off-Exchange. Issuers also may not change plan type(s) or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to state or CMS feedback until the deadline for issuer changes. CMS will monitor all data changes and contact issuers if there are concerns about changes made.

¹³ For issuers not currently participating in the PM Community, in spring 2023 CMS intends to make instructions available on how to enroll to receive information for the 2024 plan year QHP application period.

¹⁴ While some states in which an FFE is operating use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates, that data will not be submitted to CMS in states that do not perform plan management functions, and must be submitted in HIOS.

¹⁵ CMS will work with states performing plan management functions in an FFE to ensure that such guidance is consistent with federal regulatory standards and operational timelines.

Table 1.1 Data Changes

	Permitted with No State or CMS Authorization Required	Permitted with Authorization*	Not Permitted
Before the Initial Submission Deadline	All data changes permitted.	N/A	N/A
Between the Initial and Final Data Submission Deadlines	All changes are permitted, including changes in response to CMS-identified corrections, except where noted.	N/A	Issuers may not: Add new plans to a QHP application; Change an off-Exchange plan to be both on and off-Exchange; Change plan type(s) or market type; or Change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan.
After the Final Submission Deadline	N/A	Issuers may request critical data changes to align with state filings. URLs may be changed with state authorization; CMS authorization is not required.	Issuers may not change certified QHP data without the explicit direction and authorization of CMS and the state.

*Required authorization to change QHP data, and the process for requesting authorization, will differ by state Exchange model. More information is available at <https://www.qhpcertification.cms.gov>.

To withdraw a plan from QHP certification consideration, an issuer must follow the plan withdrawal process as outlined by CMS. After submission of an initial QHP application, an issuer should not remove plan data from the application templates, even if the issuer withdraws a plan. In addition, issuers seeking to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration must submit a plan withdrawal request.

After the deadline for issuer changes to QHP applications, issuers will only make corrections directed by CMS or by their state. States may direct changes by contacting CMS with a list of requested corrections. Issuers whose applications are not accurate after the final deadline for issuer submission of changes to the QHP application, and are then required to resubmit corrected

data during the limited data correction window, may be subject to compliance action by CMS.¹⁶ Issuer changes made in the limited data correction window not approved by CMS and/or the state may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After completion of the QHP certification process, CMS may offer additional data correction windows. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the state or CMS. CMS will offer windows for SHOP quarterly rate updates for issuers in an FF-SHOP. Administrative data changes such as URL updates should be made in HIOS Plan Finder or the QHP Supplemental Submission Module and do not require a data change request to CMS. URL changes require state authorization before being updated.

A request for a data change after the final submission deadline, excluding administrative changes or SHOP quarterly rate updates, may be made due to inaccuracies in or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved state filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on HealthCare.gov until the data are corrected and refreshed for consumer display.

Section 4. QHP Review Coordination with States

Each state will define the relevant submission window for state-level reviews as well as dates and processes for corrections and resubmissions. CMS will rely on states' reviews of issuer-submitted policy forms and rate filings for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines.¹⁷ States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.¹⁸ Issuers in states that do not review policy forms for compliance with federal requirements should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.¹⁹

When states perform QHP certification reviews,²⁰ they may exercise reasonable flexibility in

¹⁶ See 45 CFR 156.805(a)(5).

¹⁷ States are the primary regulators of health insurers and are responsible for enforcing the market reform provisions in title XXVII of the PHS Act both inside and outside the Exchanges. Under sections 2723 and 2761 of the PHS Act and regulations codified at 45 CFR Part 150, CMS is responsible for enforcing the provisions of Parts A and B of title XXVII of the PHS Act in a state if the state notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the provisions, or if CMS determines that the state is not substantially enforcing the requirements. As necessary, CMS will provide additional information on enforcement. In direct enforcement states, CMS enforces the market-wide provisions. The list of direct enforcement states is *available at*: <https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html>. Issuers in these states should work with CMS in instances in which this guidance references the "state," but should be aware that they will still generally continue to have some obligations under state law.

¹⁸ Refer to the forthcoming guidance from the Center for Consumer Information and Insurance Oversight, CMS, Bulletin: Timing of Submission of Rate Filing Justifications for the 2023 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2024 for further details.

¹⁹ See *supra* note 18.

²⁰ States performing plan management functions in the FFEs will conduct certification reviews. In addition, all

their application of CMS’s QHP certification standards, provided that the state’s application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in states that are performing plan management functions in the FFEs should continue to refer to state direction in addition to this guidance.

CMS expects that states will establish the timeline, communication process, and resubmission window for any reviews conducted under state authority. As noted previously, issuers should comply with any state-specific guidelines for review and resubmission related to state review standards. CMS notes that issuers may be required to submit data to state regulators in addition to what is required for QHP certification through the FFEs, if required by a state, and must comply with any requests for resubmissions from the state or from CMS in order to be certified. CMS will seek to coordinate with states so that any state-specific review guidelines and procedures are consistent with applicable federal law and operational deadlines. Issuers must meet all applicable obligations under state law to be certified for sale on the FFEs.

In states performing plan management functions in the FFEs, the state will also review QHP applications for compliance with the standards described in this guidance and will provide a certification recommendation for each plan to CMS. CMS will review the state’s QHP certification recommendations, make QHP certification decisions, and load certified QHPs on HealthCare.gov. CMS will work closely with states performing plan management functions to coordinate this process. States performing plan management functions must provide CMS with state recommendations for QHP certification in keeping with the timeline specified by CMS in order for CMS to consider the recommendations and certify QHPs, or deny certification to QHPs, including SADPs.

For states performing plan management functions in the FFEs, the SERFF data transfer deadlines will align with the HIOS submission deadlines. These state transfers should include all plans submitted to the state for certification, including SADPs for off-Exchange sale.²¹ CMS understands that all state reviews might not be complete by the submission deadlines, but as stated above, CMS requires state confirmation of approval of QHPs for sale before CMS certification.

All states are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to state guidelines separate from ACA certification requirements, as early in the certification process as practicable. For CMS to ensure this information is taken into account for certification, states must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the state plan confirmation deadline in the QHP Data Submission Timeline. CMS will provide states with detailed guidance regarding the process for submitting plan approval recommendations to CMS before the start of and throughout the QHP certification cycle. CMS will work with all state regulators to confirm by the state plan confirmation deadline that all potential QHPs meet applicable state and federal standards, and are approved for sale in the state.

Section 5. Plan ID Crosswalk

Issuers are required to submit plan ID crosswalk data for each medical QHP and SADP that was

states with FFEs, regardless of whether they perform plan management functions, will conduct certification reviews for certain review areas, as detailed in Chapter 2.

²¹ SBE-FPs should not transfer off-Exchange SADPs.

certified for the 2023 plan year. Please refer to the 2018 Letter to Issuers for more information regarding submission requirements pertinent to the Plan ID Crosswalk.

In the proposed 2024 Payment Notice, CMS proposes to allow Exchanges, beginning in plan year 2024, to modify the automatic re-enrollment hierarchy such that enrollees who are eligible for CSR in accordance with 45 CFR 155.305(g) and who would otherwise be automatically re-enrolled in a bronze-level QHP would instead be automatically re-enrolled in a silver-level QHP in the same product with a lower or equivalent net premium, provided that certain conditions are met. Furthermore, we propose to amend the Exchange re-enrollment hierarchy to allow Exchanges to ensure enrollees are re-enrolled into plans with the most similar network to the plan they had in the previous year, provided that certain conditions are met. If this proposal were finalized, the Exchanges on the Federal platform would adopt the newly permitted approach. Under this approach, issuers would continue to identify the reenrollment plan in service areas where the issuer continues to offer plans, except that the Exchanges would identify the silver reenrollment plan for bronze enrollees if those enrollees were redetermined CSR eligible. If this proposal is finalized, CMS will describe this new process in further detail in updated QHP Certification guidance for plan year 2024.

If the proposed change to the re-enrollment hierarchy is finalized, CMS intends to modify the 2024 certification approach for alternate enrollments to align with the proposed changes to 45 CFR 155.335(j) outlined in the proposed 2024 Payment Notice for QHPs that are not SADPs.

SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, CMS aims to apply the processes established for the 2023 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for SADPs offered during the 2024 plan year.

Section 6. Value-based Insurance Design

The approach for 2024 remains unchanged from 2021, 2022, and 2023. Please refer to the 2021 Letter to Issuers for more information.

Section 7. Alternative Payment Models (APMs)

The approach for 2024 remains unchanged from 2022 and 2023. Please refer to the 2022 Letter to Issuers for more information and for some possible pathways for adoption of these approaches.

Section 8. Issuer Participation for the Full Plan Year

The approach for 2024 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 9. Standardized Plan Options

The proposed approach for 2024 remains in large part unchanged from the approach in 2023. Please refer to the 2023 Letter to Issuers for a summary of these requirements. That said, there are several minor differences between the proposed approach for 2024 and the approach for 2023. First, CMS did not propose standardized plan options for the non-expanded bronze metal level for plan year 2024. Second, CMS proposed several minor updates to the plan designs to

ensure these standardized plan options have AVs within the permissible AV de minimis range for each metal level. Refer to 45 CFR 156.201 of preamble to the Notice of Benefit and Payment Parameters for 2024 proposed rule for proposed standardized plan option designs.

Regarding prescription drug formulary tiering for these standardized plan options, for PY 2024, CMS specifies that if an issuer includes the Zero Cost Share Preventive Drugs tier type in its standardized plan options, that tier type must be entered as tier one for the associated formulary ID within the Prescription Drug Template. Similarly, CMS specifies that if an issuer includes the Medical Service Drugs tier type in its standardized plan options, that tier type must be entered as the highest tier for the associated formulary ID within the Prescription Drug Template. Finally, CMS specifies that if an issuer includes both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types in their standardized plan options, then the Zero Cost Share Preventive Drugs tier type must be entered as tier one and the Medical Service Drugs tier type must be entered as final tier within the Prescription Drug Template.

Section 10. Limits to the Number of Non-Standardized Plan Options

CMS proposes at 45 CFR 156.202 of the proposed 2024 Payment Notice, as a condition of QHP certification for PY 2024 and beyond, to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including State-based Exchanges on the Federal Platform) to two non-standardized options per product network type (as described in the definition of “product” at 45 CFR 144.103) and metal level (excluding catastrophic plans), in any service area.

Similar to the approach taken to standardized plan options in the Notice of Benefit and Payment Parameters for 2023 final rule, as well as the approach taken in the current rulemaking, CMS proposes to not apply this requirement to issuers in State Exchanges, to small group market issuers, or to SADPs.

Under this proposed requirement, an issuer would, for example, be limited to offering two gold HMO and two gold PPO non-standardized plan options in that same service area in PY 2024 or any subsequent plan year.

As an additional clarifying example, if an issuer wanted to offer two Statewide bronze HMO non-standardized plan options as well as two additional bronze HMO non-standardized plan options in one particular service area that covers less than the entire State, in the service areas that all four plans would cover, the issuer could choose to offer through the Exchange either the two bronze HMO non-standardized plan options offered Statewide or the two bronze HMO non-standardized plan options offered in that particular service area (or any combination thereof, so long as the total number of non-standardized plan options does not exceed the limit of two per issuer, product network type, and metal level in the service area).

CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS

(This chapter relies on authority from ACA sections 1302, 1311(c) and (e), 1321(a), and 1402; PHS Act section 2794; and 45 CFR 146.130, 147.136, 147.138, Part 154, 155.1045, 155.1065, 156.115, 156.122, 156.125, 156.150, 156.200, 156.210, 156.221, 156.225, 156.230, 156.235, 156.410, 156.420, 156.425, 156.1110-1130, Subpart L, and 156.1250.)

This chapter provides an overview of key QHP certification standards for both QHPs and SADPs in FFEs, including those in states performing plan management functions, and how CMS or the state will evaluate and conduct reviews of 2024 QHPs and SADPs for compliance.

Section 1. Licensure and Good Standing

The approach for licensure and good standing remains unchanged from 2018 and later years. Please refer to the Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Exchanges for Plan Years 2018 and Later (“State Guidance on QHP Reviews”) for more information.²² As noted in the State Guidance on QHP Reviews, CMS does not review issuers’ compliance with licensure and good standing standards. In FFEs, including in states performing plan management functions, states will continue to ensure issuer compliance with 45 CFR 156.200(b)(4).

Section 2. Service Area

The approach for reviews of service area remains unchanged from 2023. Issuers may make changes to their plan’s service area after the initial submission deadline without first submitting a data change request for CMS authorization. After the final submission deadline listed in the Plan Year (PY) 2024 Qualified Health Plan (QHP) Data Submission and Certification Timeline,²³ a data change request is required for any change to QHP data, including service area.

Section 3. Network Adequacy

This section describes how CMS will conduct reviews of the network adequacy standards for medical QHP and SADP certification for the 2024 plan year. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

For the 2024 plan year, CMS will evaluate QHPs for compliance with network adequacy standards based on time and distance standards and appointment wait time standards. CMS will continue collecting from QHPs information on whether providers participating in their network offer telehealth services to inform future policy decision making. Finally, CMS will continue coordinating closely with state authorities to address network adequacy compliance issues, eliminate duplicative requirements or reviews, and reduce stakeholder burden.

i. Requirement to use a provider network

CMS proposes in the proposed 2024 Payment Notice to revise the network adequacy and essential community providers (ECP) standards at 45 CFR 156.230 and 45 CFR 156.235 to state that all individual market QHPs and SADPs and all SHOP plans across all Exchange-types must use a network of providers that complies with the standards described in those sections, and to remove the exception at 45 CFR 156.230(f) that these sections do not apply to plans that do not

²² See Center for Consumer Information and Insurance Oversight, CMS, Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Exchanges for Plan Years 2018 and Later (Apr. 13, 2017), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certification-Reviews-Guidance-41317.pdf>.

²³ Refer to the forthcoming guidance from the Proposed Plan Year 2024 QHP Data Submission Timeline for further details.

use a provider network, beginning with the 2024 plan year. If this proposal is finalized, an Exchange could not certify as a QHP a health plan that does not use a network of providers that complies with the network adequacy standards. This proposed revision would assure HHS that the QHP certification criteria relevant to the availability of providers conforms with the minimum QHP certification criteria described at section 1311(c)(1)(B) and (C) of the ACA.

ii. FFE Network Adequacy Reviews

The approach for FFE network adequacy time and distance reviews remains unchanged from 2023. For the 2024 plan year, the FFE network adequacy reviews will also include reviews of issuer compliance with appointment wait time standards. Please refer to the 2023 Letter to Issuers for more information.

iii. Network Adequacy for QHP Issuers in FFEs

a. Time and Distance Standards

The approach for time and distance standards remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

b. Appointment Wait Times

The approach for appointment wait time standards remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information. For the 2024 plan year, issuers will demonstrate compliance with appointment wait time standards via attestation, as finalized in the 2023 Payment Notice. Issuers must work with their network providers to collect the necessary data to assess appointment wait times and determine if their provider network meets the wait time standards detailed in the 2023 Letter to Issuers.

iv. Network Adequacy Justification Process

As for the 2023 plan year, if an issuer's application does not satisfy the network adequacy standard, an issuer would be required to include a satisfactory justification as part of its application for QHP certification. The justification process remains unchanged from the 2023 plan year. CMS will accept only the official Network Adequacy Justification Form, which is a partially-prepopulated Excel document. CMS will review any updated provider data submitted on the issuer's ECP/NA template and completed Network Adequacy Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, before making the certification decision. CMS will continue to monitor network adequacy throughout the year and will coordinate with state departments of insurance should it be necessary to remedy potential corrections and/or consider the extent to which any barriers beyond the issuer's control might be impeding an issuer's ability to satisfy the network adequacy standards.

CMS reminds issuers that an issuer choosing to enter into an exclusivity contract with a provider is not a sufficient justification to allow that issuer to fail to satisfy the network adequacy standards. However, if a provider has entered into an exclusivity contract with another issuer, CMS recognizes that competing issuers will be unable to contract with that provider. Similarly, CMS recognizes the potential impact of provider supply shortages and topographic barriers on an issuer's ability to satisfy the network adequacy standards. If an issuer encounters any such

barriers directly impacting the issuer’s ability to satisfy the network adequacy requirements, the issuer should document the nature and extent of the barrier within their Network Adequacy Justification using the official partially-prepopulated form. This will ensure that CMS is aware of the potential barrier(s) so that CMS can more accurately assess the issuer’s satisfaction of the network adequacy standard once CMS confirms the nature and extent of the barrier. In the meantime, CMS expects such issuers to demonstrate to CMS via their Network Adequacy Justification how they are continuing to monitor their service area throughout the year for new providers that may enter their service area for the purpose of offering them a contract to help fill any network adequacy gaps identified by CMS.

For rural counties and counties with extreme access considerations (CEAC) for which issuers report within the issuer’s NA Justification a provider supply shortage of primary care pediatricians, we will allow the family medicine physician provider type to count toward satisfaction of the “Primary Care – Pediatric” specialty type. This would be in addition to the family medicine physician provider type currently counting toward issuer satisfaction of the “Primary Care – Adult” specialty type.

v. Telehealth Services

The approach for telehealth services remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

vi. Network Transparency

The approach for network transparency remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

Section 4. Essential Community Providers

At 45 CFR 156.235, CMS established QHP issuer requirements for inclusion of ECPs in provider networks, which requires that issuers include at least a certain threshold percentage, as determined by the Department of Health and Human Services (HHS), of available ECPs (based on a non-exhaustive HHS ECP List provided to issuers and updated annually) within the plan’s service area in the issuer’s provider network(s). The ECP standard for the 2024 plan year and the approach for reviews of the ECP standard, as stated in the proposed 2024 Payment Notice, would remain the same as for the 2023 plan year, with the exception of the changes noted below. Please refer to the 2018 Letter to Issuers for full details.

i. Requirement to use a provider network

CMS proposes in the proposed 2024 Payment Notice to revise the network adequacy and ECP standards at 45 CFR 156.230 and 45 CFR 156.235 to state that all individual market QHPs and SADPs and all SHOP plans across all Exchange-types must use a network of providers that complies with the standards described in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network, beginning with the 2024 plan year. If this proposal is finalized, an Exchange could not certify as a QHP a health plan that does not use a network of providers that complies with the ECP standards. This proposed revision would assure HHS that the QHP certification criteria relevant to the availability of providers conforms with the minimum QHP certification criteria described at section 1311(c)(1)(B) and (C) of the ACA.

ii. Addition of two new major ECP categories

In the proposed 2024 Payment Notice, CMS proposes to make changes to the ECP categories, as follows:

- Replace the “Community Mental Health Centers” provider type, currently included in the “Other ECP Providers” category with specific qualifying provider types enumerated at 45 CFR 156.235(a)(2)(ii)(B), with a separate, newly established “Mental Health Facilities” ECP category.
- Replace the “SUD Treatment Centers” provider type, currently included in the “Other ECP Providers” category, into the newly established “Substance Use Treatment Centers” ECP category.
- Add Rural Emergency Hospitals as a provider type in the “Other ECP Providers” ECP category. This addition reflects the fact that on or after January 1, 2023, REHs may begin participating in the Medicare program.

If these changes are finalized as proposed, the eight (8) stand-alone ECP categories and their associated provider types would consist of:

Table 2.1: ECP Categories and Provider Types in FFEs, as proposed for PY 2024 and beyond

Major ECP category	ECP provider types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC “Look-Alike” Clinics
Ryan White Program Providers	Ryan White HIV/AIDS Providers
Family Planning Providers	State-owned family planning service sites, Governmental family planning service sites, including Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics, Not-for-profit family planning service sites that do not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding
Indian Health Care Providers	Tribes, Tribal Organization and Urban Indian Organization Providers, Indian Health Service Facilities
Inpatient Hospitals	Disproportionate Share Hospital (DSH), Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals,
Substance Use Disorder Treatment Centers	Substance Use Disorder Treatment Providers
Mental Health Facilities	Community Mental Health Centers, Other Mental Health Providers
Other ECP Providers	Black Lung Clinics, Hemophilia Treatment Centers, Rural Health Clinics, Sexually Transmitted Disease Clinics, Tuberculosis

Major ECP category	ECP provider types
	Clinics, Rural Emergency Hospitals

QHP issuers would be required to offer a contract in good faith to at least one ECP in each of the available eight ECP categories in each county in the plan’s service area, including the two newly created stand-alone categories of Mental Health Facilities and Substance Use Disorder Treatment Centers.²⁴ The existing provider type of Community Mental Health Centers would crosswalk into the newly created, stand-alone Mental Health Facilities ECP category on the HHS ECP list. If finalized as proposed, the inclusion of substance use disorder treatment centers and mental health facilities on the HHS ECP List would be limited to those facilities identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or CMS as providing such services, in addition to fulfilling other ECP qualification requirements as specified at 45 CFR 156.235(c).

iii. Application of 35 percent ECP threshold to two major ECP categories, in addition to the overall 35 percent threshold

For the 2024 plan year, the provider participation threshold remains at 35 percent of available ECPs in the plan’s service area, including approved ECP write-ins, which also count toward the issuer’s satisfaction of the 35 percent threshold. In the proposed 2024 Payment Notice, in addition to this overall 35 percent threshold, CMS proposes to also apply the 35 percent threshold to two (2) of the major ECP categories: Federally Qualified Health Centers (FQHCs) and Family Planning Providers. If finalized as proposed, this requirement would require medical QHP issuers to contract with at least 35 percent of FQHCs and at least 35 percent of Family Planning Providers in the plan’s service area. SADP issuers would be required to contract with at least 35 percent of FQHCs offering dental services in the plan’s service area. For both medical QHPs and SADPs, these contracts would also count toward the separate overall 35 percent threshold, which remains in place.

Based on data from the 2023 plan year, it is likely that a majority of issuers would be able to meet or exceed the threshold requirements for FQHCs and Family Planning Providers without needing to contract with additional providers in these categories. To illustrate, if these requirements had been in place for the 2023 plan year, out of 137 QHP issuers on the FFE, 76 percent would have been able to meet or exceed the 35 percent FQHC threshold, while 61 percent would have been able to meet or exceed the 35 percent Family Planning Provider threshold without contracting with additional providers. For SADP issuers, 84 percent would have been able to meet the 35 percent threshold requirement for FQHCs offering dental services without contracting with additional providers.

In the 2023 plan year, for medical QHPs, the mean and median ECP scores for the FQHC category were 74 and 83 percent, respectively. For the Family Planning Providers category, the mean and median ECP scores were 66 and 71 percent, respectively. For SADPs, the mean and median ECP scores for the FQHC category were 61 and 64 percent, respectively.

iv. ECP Justification Process

²⁴ Pursuant to 45 CFR 156.235(a)(2)(ii)(A), QHP issuers must offer a contract to all available Indian health care providers in the service area, rather than to only one Indian health care provider in each county in the plan’s service area.

As described in the 2018 Letters to Issuers, HHS prepares the applicable plan year HHS ECP list that potential QHPs use to identify eligible ECP facilities. If an issuer's application does not satisfy the ECP standard, an issuer would be required to include a satisfactory justification as part of its application for QHP certification. The justification process remains unchanged from the 2023 plan year. As for the 2023 plan year, CMS will accept only the official ECP Justification Form, which is a partially-prepopulated Excel document.

CMS reminds issuers that the decision to enter into an exclusivity contract with a provider is not a sufficient justification to allow an issuer to fail to satisfy the ECP standards. However, if a provider that appears on the HHS ECP List has entered into an exclusivity contract with another issuer, CMS recognizes that competing issuers will be unable to contract with that provider. Such exclusivity contracts disqualify the provider from inclusion on the HHS ECP List and will result in the provider's removal from the list to ensure that other issuers will not be penalized for failing to contract with the provider. As a result of the provider's disqualification from the HHS ECP List, the provider also will not be counted toward meeting the ECP threshold for the issuer with which it has the exclusive contract.

CMS may also remove a provider from the HHS ECP List after release of the respective plan year's final ECP List for reasons including facility closure, discontinuance of dental services (such that the provider can no longer participate in the provider network of an SADP), loss of ECP status (e.g., termination of 340B status or Health Professional Shortage Area designation, etc.), or demonstrated lack of interest in contracting with any Exchange issuers. While CMS conducts outreach to providers year-round to ensure their continued ECP status and interest in contracting with Exchange issuers, if an issuer encounters any such barriers to contracting with providers that appear on the HHS ECP List, the issuer should document the nature and extent of the barrier within their ECP Justification using the official partially-prepopulated form. This will ensure that CMS is aware of the provider's possible change in circumstance so that CMS can more accurately assess the issuer's satisfaction of the ECP standard once CMS confirms the respective provider's change in circumstance directly with either the provider or the designating entity (e.g., the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, Indian Health Service), as appropriate.

Finally, when a provider has failed to respond to an issuer's outreach attempt, the issuer should document such an outcome in their ECP Justification as the provider failing to respond and then reach out to another available provider within the same ECP category within the plan's service area in order to offer a contract in satisfaction of the requirement that the issuer offer a contract to at least one ECP in each ECP category in each county within the plan's service area. In other words, the requirement to offer contracts to at least one ECP in each category in each county in the service area can only be fulfilled by making actual contract offers. Provider outreach attempts alone are insufficient.

Section 5. Accreditation

The approach for reviews of the accreditation standard remains largely unchanged from 2020. HHS continues to encourage issuers to provide their accrediting entity (AE) the HIOS ID number associated with their organization as they begin to work with the AE(s) on accreditation.

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards remains unchanged from

2017 and later years. Please refer to the 2017 Letter to Issuers for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds. CMS will continue to assess these standards and any related burden for issuers and hospitals.

Section 7. Quality Reporting

The approach for review of QHP issuer compliance with quality reporting standards related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey) remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information, and to the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023²⁵ for more detailed information on issuer data collection and reporting requirements for the 2023 calendar year.

At this time, QRS and QHP Enrollee Survey reporting requirements do not apply to indemnity plans, SADPs, or to child-only plans offered on Exchanges. The QRS and QHP Enrollee Survey requirements also do not apply to Basic Health Program (BHP) plans.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2024 plan year.

At this time, the QIS requirements do not apply to SADPs or to child-only plans offered on Exchanges.

Section 9. Review of Rates and Forms

The approach for reviewing rate filings for the 2024 plan year remains unchanged from the 2020 Letter to Issuers. Please refer to the 2020 Letter to Issuers and the Unified Rate Review Instructions for more information.²⁶

Issuers in states with an Effective Rate Review Program that use SERFF are now able to comply with the requirement to submit rate filing justifications to CMS by submitting the rate filing directly in SERFF. New functionality is available beginning with the 2023 plan year, such that a rate filing filed in SERFF is automatically uploaded to the Uniform Rate Review (URR) Module of HIOS and will be considered filed with CMS once submitted in SERFF.²⁷ This new functionality does not apply to states that do not have an Effective Rate Review Program²⁸ and

²⁵ See Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023 (September 2022), available at: <https://www.cms.gov/files/document/2023-qrs-qhp-enrollee-survey-technical-guidance.pdf>

²⁶ See, e.g., the 2023 Unified Rate Review Instructions, available at: <https://www.cms.gov/files/document/urr-py23-instructions.pdf>.

²⁷ For additional details and operational guidance on submission of the URR template to CMS through SERFF, see the 2023 Unified Rate Review Instructions, available at: <https://www.cms.gov/files/document/urr-py23-instructions.pdf>.

²⁸ CMS will be responsible for reviewing the 2024 plan year rate filings in two states that do not have an Effective Rate Review Program (Oklahoma and Wyoming).

states that do not participate in SERFF. Issuers in those states will need to continue to submit the URR template directly in HIOS. These same guidelines apply to issuers in states that do not perform plan management functions and otherwise submit QHP application data in HIOS.

CMS will rely on states' reviews of issuer-submitted policy forms for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines. Issuers in states that do not review policy forms for federal compliance should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.²⁹ These issuers will have to submit two sets of the same policy form filings. One filing will be submitted to the state through the state instance of SERFF and the second filing will be submitted to CMS through the CMS instance of SERFF.³⁰

Section 10. Discriminatory Benefit Design

The approach to discriminatory benefit design generally remains unchanged from 2017 and later years. Please refer to the 2017 Letter to Issuers for more information regarding discriminatory benefit design and QHP discriminatory benefit design. The plan year 2023 Payment Notice refined the essential health benefits (EHB) nondiscrimination policy for health plan designs. CMS will assess compliance of QHPs in the FFEs by ensuring consistent application of EHB nondiscrimination policy, which will better safeguard consumers who depend on nondiscrimination protections. While states are generally the primary enforcers of EHB policy, CMS will continue to monitor issuer compliance with EHB nondiscrimination policy and provide technical assistance and available data, research, or other information to states. CMS will assess benefit designs to ensure they are nondiscriminatory and consistent with 45 CFR 156.125, regardless of how a discriminatory benefit design originated.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information. For the 2024 plan year, CMS will begin conducting an adverse tiering review as part of the non-discrimination formulary cost share review. The adverse tiering review will check whether QHP enrollees have access to drugs or drug classes prescribed to treat chronic, and high-cost medical conditions at lower cost tiers, to ensure that issuers are not placing drugs related to a specific condition on a high-cost prescription drug tier in order to actively discourage enrollment by individuals with that condition in the plan. For PY 2024, CMS will include the following medical conditions in the adverse tiering review: hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis. Drugs and drug classes in each condition under review are FDA approved, first-line therapies, as recommended by nationally recognized clinical guidelines.

²⁹ See *supra* note 18.

³⁰ The database utilized by SERFF is divided into subsections called "instances." Every form filing belongs to one state instance and one industry instance. See the 2021 SERFF Complete State Manual, page 12, *available at*: <https://www.serff.com/> via "Profile," "Help," "User Manual."

Section 12. Third Party Payment of Premiums and Cost Sharing

Requirements related to QHP and SADP issuers' acceptance of third-party payments of premiums and cost sharing on behalf of QHP enrollees remain unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 13. Cost-sharing Reduction Plan Variations

The approach for issuers to provide cost-sharing reductions (CSRs) to consumers through CSR plan variations remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information. Eligible consumers can enroll in these plan variations for the 2024 plan year and will continue to receive CSRs provided by issuers. Since October 2017, CMS has not made CSR payments to issuers and cannot make CSR payments unless Congress appropriates funds for these payments.

Section 14. Data Integrity Review

The approach for conducting data integrity reviews remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 15. Requirements for Plan Marketing Names

In the proposed 2024 Payment Notice, CMS proposes a requirement that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading.³¹ As described in the proposed 2024 Payment Notice, starting in the 2024 plan year, CMS would review plan and plan variation marketing names for misleading information, inaccurate information, or omission of material fact during the annual QHP certification process.

Plan Marketing Name Guidance

All information included in plan and plan variation marketing names that relates to plan attributes should correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and in other materials submitted as part of the QHP certification process such as any content that is part of the Summary of Benefits and Coverage. If necessary, this information can be included in the "Benefit Explanation" field of the Plans & Benefits Template. Consumers applying for coverage should be able to understand references to benefit information in plan marketing names, and they should be able to confirm any information from a plan marketing name in the plan's publicly-available benefit descriptions. Also, plan benefit or cost sharing information in a plan or plan variation marketing name should not conflict with plan information displayed on HealthCare.gov during the plan selection process in terms of dollar amount and, where applicable, terminology.

³¹ In practice, CMS and stakeholders often use the term "plan variants" to refer to "plan variations." Per 45 CFR § 156.400, plan variation means a zero-cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation. Issuers may choose to vary plan marketing name by the plan variant – for example, use one plan marketing name for a silver plan that meets the actuarial value (AV) requirements at 45 CFR 156.140(b)(2), and a different name for that plan's equivalent that meets the AV requirements at 45 CFR 156.420(a)(1), (2), or (3).

Examples of information that should be validated to ensure accuracy and consistency across the plan or plan variation marketing name, Plans & Benefits Template, HealthCare.gov plan selection information, and other applicable QHP certification materials:

- a. Deductible amounts
- b. For tiered or network-specific benefits, which tier or network is referenced
- c. Maximum out of pocket (MOOP) amounts
- d. Benefit copay or coinsurance
- e. Initial free or discounted visits
- f. Ability of the plan to be paired with a health savings account (HSA)³²

Section 16. Interoperability

The Interoperability and Patient Access Final Rule³³ was finalized on May 1, 2020. For the 2024 plan year, the policy remains unchanged from the 2022 plan year. To assess compliance with all interoperability requirements, the FFEs will require QHP issuers to attest that they are meeting the requirements at 45 CFR 156.221 or submit a justification as part of the QHP application. As noted in the final rule, the interoperability requirements specifically exclude QHP issuers on the FFEs offering only SADPs or issuers only offering QHPs in the FF-SHOPS.

As noted in the Notification of Enforcement Discretion released on December 10, 2021,³⁴ CMS has opted to employ enforcement discretion for 45 CFR 156.221(f), known as the payer-to-payer data exchange provision, which instructs issuers to maintain a process for the electronic exchange of data classes and elements with other payers for current and prior enrollees. Enforcement of the payer-to-payer data exchange requirement is delayed and will not be incorporated in QHP certification for the 2024 plan year. QHP issuers are encouraged to review the Federal Register notice referenced above announcing enforcement discretion for more

³² An HSA is a tax-exempt trust or custodial account that a taxpayer may set up with a qualified HSA trustee to pay or reimburse certain medical expenses the taxpayer incurs. (See IRS Publication 969 (2021), Health Savings Accounts and Other Tax-Favored Health Plans: https://www.irs.gov/publications/p969#en_US_2021_publink1000204030.) Taxpayers must meet certain requirements to qualify for an HSA, including being enrolled in a High Deductible Health Plan (HDHP) as defined in section 223(c)(2) of the Internal Revenue Code. HDHP requirements include minimum levels for family and individual deductible amounts – for example, for calendar year 2022, an HDHP was defined as a health plan with an annual deductible not less than \$1,400 for self-only coverage or \$2,800 for family coverage, with annual out-of-pocket expenses not more than \$7,050 for self-only coverage or \$14,100 for family coverage. (See IRS Rev. Proc. 2021-25: <https://www.irs.gov/pub/irs-drop/rp-21-25.pdf>.) Plan variants with limited or no cost sharing, such as those described at 45 CFR 156.420(a)(1) and (b)(1), by definition do not meet the requirements to be HDHPs, and enrollees in these plans therefore cannot contribute to an HSA. CMS will consider references to HSAs in the names of plans that do not qualify as HDHPs to be incorrect and misleading.

³³ See Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers Final Rule, 85 FR 25,510 (May 1, 2020), available at: <https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf>.

³⁴ See Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers Notification of Enforcement Discretion, 85 Fed. Reg. 70,412 (Dec 10, 2021), available at: <https://www.govinfo.gov/content/pkg/FR-2021-12-10/pdf/2021-26764.pdf>.

information.³⁵

CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a); and 45 CFR 147.200, 147.210-212, 155.706(a), 156.122, 156.220, 156.230, and 156.286.)

Section 1. Consumer Support Tools

CMS developed several decision support tools and publishes certain plan data to empower patients to understand their insurance options and select a plan through an FFE or SBE-FP, including through an FF-SHOP. Please refer to the 2018 Letter to Issuers for more information on these consumer support tools, including provider and formulary search functions and the out-of-pocket cost comparison tool.

Section 2. Transparency in Coverage Reporting

This section provides an overview of the transparency reporting requirements for all QHP issuers, including SADP issuers, in the FFEs, including in states that are performing plan management functions.

Pursuant to 45 CFR 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection request, CMS-10572, “Transparency in Coverage Reporting by Qualified Health Plan Issuers,” under the Paperwork Reduction Act (PRA) to OMB for an additional 3-year collection period. This updated information collection request was approved on April 12, 2022, and will cover collections for the 2024 and 2025 plan years. Starting in the 2024 plan year, the data collection elements that QHP issuers reported from 2020 to 2023 will remain part of this collection, and issuers will also be required to respond to additional items assessing in- and out-of-network claims outcomes at the issuer level, and reasons for claims denials at the plan level. Transparency in Coverage URL submissions should be made in the QHP Supplemental Submission Module at the time of QHP application submission.

Section 3. Medical Cost Scenarios

Consumer testing of the summary of benefits and coverage (SBC) shows that hypothetical medical scenarios illustrating the consumer portion of medical costs, such as those found on the SBC, help consumers understand and compare health plan coverage options. CMS will continue to analyze ways to provide additional medical cost scenarios to QHP customers.

CHAPTER 4: STAND-ALONE DENTAL PLANS: 2024 APPROACH

(This chapter relies on authority from ACA sections 1311(c), (d), and (e) and 1321(a); and 45 CFR 156.150.)

The approach for submitting applications for certification of SADPs remains unchanged from

³⁵ Note that CMS recently published a notice of proposed rulemaking on Advancing Interoperability and Improving Prior Authorization Processes, available at: <https://public-inspection.federalregister.gov/2022-26479.pdf>. A more detailed summary of these proposals, which have a proposed compliance date of 2026, can be found here: <https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact>.”

2023, with the exception of additional standards that would be effective beginning in the 2024 plan year if finalized as proposed, as described in Sections 3 and 4 below. Please refer to the 2018 and 2023 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For the 2024 plan year, the SADP annual limitation on cost sharing for one covered child is \$350 increased by the 15.336 percentage point increase in the Consumer Price Index (CPI) for dental services of 528.630 for 2022 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by \$53.68 to a total of \$403.68. The regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of \$25, meaning the annual limitation on cost sharing for SADPs for the 2024 plan year will be \$400 for one child and \$800 for two or more children. For more information on how this limitation is determined, please refer to 45 CFR 156.150 and to the 2018 Letter to Issuers.

Section 2. SADP Actuarial Value Requirements

The approach to actuarial value requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021. Please refer to the 2021 Letter to Issuers for more information. For the 2024 plan year, SADP issuers may offer the pediatric dental EHB at any actuarial value. SADP issuers will be required to certify the actuarial value of each SADP's coverage of pediatric dental EHB.

Section 3. SADP Age on Effective Date Methodology Requirement

In the proposed 2024 Payment Notice, CMS proposes at 45 CFR 156.210(d)(1) to require SADP issuers, as a condition of Exchange certification, to use an enrollee's age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee's age for rating and eligibility purposes, beginning with Exchange certification for PY 2024. CMS proposes that this requirement apply to all Exchange-certified SADPs, whether they are sold on- or off-Exchange.

As stated in the proposed 2024 Payment Notice, requiring SADP issuers to use the age on effective date methodology for calculating an enrollee's age, and consequently removing the less commonly used and more complex age calculation methods, would reduce potential consumer confusion and promote operational efficiency.

Section 4. SADP Guaranteed Rates Requirement

In the proposed 2024 Payment Notice, CMS proposes at 45 CFR 156.210(d)(2) to require SADP issuers, as a condition of Exchange certification, to submit guaranteed rates beginning with Exchange certification for PY 2024. CMS proposes that this requirement apply to all Exchange-certified SADPs, whether they are sold on- or off-Exchange.

As stated in the proposed 2024 Payment Notice, this proposed change would help reduce the risk of incorrect advance premium tax credit (APTC) calculation for the pediatric dental EHB portion of premiums, thereby reducing the risk of consumer harm.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

(This chapter relies on authority from ACA sections 1311(c) and (d), and 1321(a); and 45 C.F.R. § 147.104(e), 45 C.F.R. §§ 155.201, 155.220, 155.221, and 155.1010, and 45 C.F.R. §§ 156.200, 156.225, 156.260, 156.272, 156.340, 156.705, 156.715, and 156.1230.)

Guidance on QHP issuer account management, issuer compliance monitoring, issuer compliance reviews, and issuer participation for the full plan year generally remains unchanged from 2018 and later years. Please refer to the Letter to Issuers from 2018 and letters from later years for more information.

Section 1. Provide Issuers New Information Regarding the Registration Completion List and Health Line of Authority Check

Pursuant to 45 CFR 156.340, a QHP issuer participating in the FFEs, including FFEs where states perform plan management functions,³⁶ maintains responsibility for ensuring that its delegated and downstream entities, including affiliated agents and brokers, comply with applicable laws and regulations.³⁷ Accordingly, QHP issuers must confirm all affiliated agents' and brokers' licensure statuses, and verify fulfillment of the applicable FFE registration and training requirements before allowing access to the QHP issuers' tools to assist with enrollment through the FFEs and/or providing compensation³⁸ for active Exchange transactions. QHP issuers in the FFEs, including FFEs where states perform plan management functions, must verify agents' and brokers' FFE registration and training status for each plan year by visiting the CMS agent and broker resources page and linking to the Registration Status Lists (Registration Completion List (RCL) and Registration Termination List (RTL)) on data.HealthCare.gov.³⁹

For the current plan year, the agent and broker FFE RCL has an NPN Validation column. The indicator in the NPN Validation column reflects the check CMS performs against the National Insurance Producer Registry (NIPR <https://www.nipr.com>) database. A valid National Producer Number (NPN) and an active licensure status in a health-related line of authority (<https://data.healthcare.gov/AB-NIPR-Health-Line-Of-Authority>) are required in the resident state for display of a "Yes" in this column.

CMS intends to continue to work with states as well as issuers to monitor the activities of agents

³⁶ Agents and brokers assisting Exchange consumers in an SBE-FP must also complete applicable FFE registration and training requirements. See 45 CFR 155.220(a)(1).

³⁷ QHP issuers participating in SBE-FPs also maintain responsibility for ensuring their delegated and downstream entities, including affiliated agents and brokers, comply with applicable laws and regulations. See 45 CFR 156.340(a)(2).

³⁸ Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker. See, e.g., Frequently Asked Questions on Agent/Broker Compensation and Guaranteed Availability of Coverage, (June 7, 2022), available at: <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf>.

³⁹ See FFM Agent Broker Registration Status Lists available at:

https://data.healthcare.gov/ffm_ab_registration_lists. See RCL and RTL data dictionaries available at: <https://data.healthcare.gov/AB-NIPR-Health-Line-Of-Authority> and https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/62416-AB-Registration-Completion-List-Data-Dictionary-Web_v1.pdf. QHP issuers participating in the FFEs, including Exchanges where States perform plan management functions, as well as the SBE-FPs may use the "expiration date" on the RCL, or the Registration Termination List, to check for suspension or termination (voluntary or for cause) of an agent's or broker's registration status for a particular plan year.

and brokers participating in the Exchanges that rely on the Federal Platform, and prevent fraud, waste, and abuse.

CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a); PHS Act sections 2715 and 2719; and 45 CFR 147.136, 147.200, Part 155 Subpart C, and 156.1010.)

Section 1. Coverage Appeals

The approach to coverage appeals generally remains unchanged. Please refer to the 2023 Letter to Issuers for more information.

Under 45 CFR 147.136(d)(4), insured coverage in states that do not have an applicable state external review process, including with regard to compliance with the expanded scope of external reviews to include surprise billing and cost-sharing protections under sections 2799A-1 or 2799A-2 of the PHS Act (No Surprises Act (NSA) compliance matters), may satisfy the requirement to provide for external review of adverse determinations by electing to use the Federal HHS-administered external review process.

Alternatively, plans and issuers subject to an applicable state external review process that cannot accommodate external review of NSA compliance matters may choose to use the accredited independent review organization (IRO) contracting Federal External Review process for NSA compliance matters only (45 CFR 147.136(d)(1)-(3)).

Plans and issuers may contact their respective departments of insurance for additional guidance regarding their state's ability to accommodate external review requests for NSA compliance matters. More information is available in Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the No Surprises Act.⁴⁰

Section 2. Consumer Case Tracking

The approach to consumer case tracking remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 3. Meaningful Access

This section summarizes the laws, regulations, and guidance that require QHP issuers (including SADP issuers) to take reasonable steps to ensure meaningful access by limited English proficiency (LEP) speakers and individuals with disabilities.

The approach to meaningful access generally remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

Section 4. Summary of Benefits and Coverage (SBC)

⁴⁰ The Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the No Surprises Act is available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NSA-Guidance.pdf>.

The guidance on the SBC remains unchanged. Please refer to the 2022 Letter to Issuers for more information.

CHAPTER 7: TRIBAL RELATIONS AND SUPPORT

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a).)

CMS guidance concerning Indian health care providers remains unchanged from 2018 and later years. For more information, please refer to the 2018 Letter to Issuers.⁴¹

⁴¹ The model QHP Addendum for Indian health providers is *available at*:
https://www.qhpcertification.cms.gov/s/Model_QHP_Addendum_Indian_Health_Care_Providers.pdf?v=1.