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**From: Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)**

**Title: 2026 Final Letter to Issuers in the Federally-facilitated Exchanges**

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2026 Final Letter to Issuers in the Federally-facilitated Exchanges (2026 Final Letter). This 2026 Final Letter provides updates on operational and technical guidance for the 2026 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFEs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of this 2026 Final 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 2026. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2026 Final Letter focuses on guidance that has been updated for the 2026 plan year, and refers issuers to the 2017 through 2025 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.[1] CMS notes that the policies articulated in

[1] *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-

this 2026 Final Letter apply to the QHP certification process for plan years beginning in 2026.[2] Throughout this 2026 Final 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 2026 Final Letter are to Title 45 of the CFR.[3] While certain parts of the 2026 Final Letter explain associated regulatory requirements, the 2026 Final Letter is not a complete list of regulatory requirements for issuers.

Federally-facilitated-Marketplaces.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2023 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 28, 2022), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf; 2024 Final Letter to Issuers in the Federally-facilitated Marketplaces (May 1, 2023), *available at*: https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf; 2025 Final Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 10, 2024), *available at*: https://www.cms.gov/files/document/2025-letter-issuers.pdf.

[2] Plan years in the FF-SHOPs will not always align with calendar year 2026.

[3] Available at: https://ecfr.federalregister.gov/current/title-45.

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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 while the State is enforcing the insurance market reforms added to the Public Health Service (PHS) Act by the ACA, or by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA); (2) States performing plan management functions and making QHP certification recommendations to CMS and where the State does not enforce insurance market reforms added to the PHS Act by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA;[4] (3) States where CMS is performing all plan management functions and certifying QHPs while the State is enforcing the insurance market reforms in the PHS Act, and; (4) States where CMS is performing all plan management functions and where the State does not enforce insurance market reforms added to the PHS Act by the ACA,[5] or by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA.[6] 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 forthcoming final Plan Year (PY) 2026 Qualified Health Plan (QHP) Data Submission and Certification Timeline.

Issuers will submit a complete QHP application for plans they intend to have certified in a State in which an FFE is operating.[7] CMS will review QHP applications for all issuers applying for

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[4] CMS published letters to States that are not enforcing provisions of the PHS Act extended or added by the CAA *available at*: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA.

[5] The list of States that do not enforce the ACA market wide-requirements is *available at:* https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html.

[6] 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 2026 Final Letter.

[7] *See* CMS-10433, "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," under the PRA for reference (OMB Control Number 0938-1187),

QHP certification in an FFE[8] 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.

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.[9] 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 final Plan Year 2026 QHP Data Submission and Certification 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 final Plan Year 2026 QHP Data Submission and Certification

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[8] 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.

[9] *See* additional information on the plan withdrawal process *available at:* https://www.qhpcertification.cms.gov/s/Plan%20Withdrawal%20FAQs.

[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.

Timeline and to make necessary updates to the QHP application before the last deadline for issuer submission. Additionally, issuers must comply with any applicable CMS requirements related to rate and form filings. There are certain States where CMS is directly performing rate review and/or 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 Plan Management (PM) Community to receive relevant 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 the Marketplace Plan Management System (MPMS) module of 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, and may have additional required submissions in MPMS.[15] 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.[16]

All issuers applying for QHP certification for the 2026 plan year must validate their QHP application data in the Plan Validation Workspace (Workspace). The Workspace is the section within MPMS in which issuers upload and validate QHP application templates prior to submission. The Workspace will validate template data for data integrity and compliance with a variety of federal standards, including standardized plan options, and allow issuers to view and

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[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/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-User-Manual.pdf. CMS expects issuers to use the same HIOS plan identification numbers for plans, including SADPs, submitted for certification for the 2026 plan year that are the same as plans, including SADPs, certified as QHPs for the 2025 plan year, as "plan" is 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 2026 plan year if the plan has not changed since the SADP was certified for the 2025 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 essential health benefit (EHB) at a specified actuarial value (AV). 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 2026 plan year that had been certified for the 2025 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

[13] For issuers not currently participating in the PM Community, please refer to the Register for Updates webpage for more information, *available at:* https://www.qhpcertification.cms.gov/s/Register%20for%20Updates.

[14] *See* more information on QHP Certification submission systems, including MPMS, *available at:* https://www.qhpcertification.cms.gov/s/Submission%20Systems.

[15] While some States in which an FFE is operating use 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.

[16] 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.

update pre-submission review results. Issuers will be able to submit their applications to CMS via the HIOS MPMS Module or to their State via SERFF after all validation errors are resolved. CMS encourages issuers to review frequently asked questions about the MPMS system at https://www.qhpcertification.cms.gov/s/MPMS%20FAQs.

CMS encourages issuers to access Plan Preview in MPMS 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 also 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 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.

**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 as noted above. | N/A | Issuers may not:<br>Add new plans to a QHP application;<br>Change an off-Exchange plan to be both on and off-Exchange;<br>Change plan type(s) or market type; or<br>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.<br>URLs (with the exception of transparency in coverage and interoperability URLs) may be changed with applicable 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 Final Submission Deadline for issuer changes to QHP applications, issuers can only make corrections directed by CMS or by their State. States may direct issuers to submit a data change request to CMS that documents State-approved corrections. If CMS approves the data change request, then CMS will open a submission window for the issuer to submit the approved 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 a limited data correction window, may be subject to compliance action by CMS.[17] Issuer changes made in a 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. Issuers must submit URL updates in MPMS and are not required to submit a data change request to CMS for such changes. URL changes require applicable 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 in 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 with an Effective Rate Review Program's reviews of issuer-submitted rate filings for reasonableness and compliance with market-wide standards as part of its QHP certification process, provided that States complete the reviews in a manner consistent with FFE operational timelines.[18] States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for

[17] *See* 45 CFR 156.805(a)(5).

[18] CMS will be responsible for reviewing the 2026 plan year rate filings in three States that do not have an Effective Rate Review Program (Oklahoma, Tennessee, and Wyoming).

rate filings for the appropriate plan year coverage.[19] Similarly, CMS, as part of its QHP certification process, will rely on States' reviews of issuer-submitted policy forms for compliance with Federal laws and regulations for which the State has enforcement authority, provided that States complete the reviews in a manner consistent with FFE operational timelines.[20] Issuers in States that do not review policy forms for compliance with all applicable Federal requirements should consult forthcoming guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.[21]

When States perform QHP certification reviews,[22] they may exercise reasonable flexibility in their application of CMS' 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.

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[19] *See* Bulletin: Timing of Submission of Rate Filing Justifications for the 2025 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2026 *available at:* https://www.cms.gov/files/document/2025-rate-review-bulletindocx-508-compliant.pdf.

[20] States are the primary regulators of health insurers and are responsible for enforcing the consumer protections and market reform provisions amended or extended by the ACA and CAA, as well as other Federal requirements, 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, B, and D of title XXVII of the PHS Act with respect to health insurance issuers in the individual and group markets when the State informs CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the applicable statutory provisions, or if CMS determines that the State is not substantially enforcing one or more of the applicable provisions. As necessary, CMS will provide additional information on enforcement. CMS reviews form filings from issuers in Missouri, Oklahoma, Tennessee, Texas, and Wyoming (direct enforcement States) for compliance with the ACA market reform provisions and other applicable Federal requirements in title XXVII of the PHS Act that CMS is responsible for enforcing. In addition, CMS is reviewing form filing submissions for compliance with certain CAA provisions from issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming. CMS published letters to States that are not enforcing provisions of the PHS Act extended or added by the CAA *available at*: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA. Issuers in these States and the direct enforcement 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.

[21] Refer to the forthcoming guidance from the Center for Consumer Information and Insurance Oversight, CMS: Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2026.

[22] States performing plan management functions in the FFEs will conduct certification reviews. In addition, all States with FFEs, regardless of whether they perform plan management functions, will conduct certification reviews for certain review areas, as detailed in Chapter 2.

CMS will seek to coordinate with States so that any State-specific review guidelines and procedures are met along 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 onto 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 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.[23] 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 Federal guidelines during 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 final Plan Year 2026 QHP Data Submission and Certification 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 individual market QHP that was certified and offered on the Exchange for the 2025 plan year. These data will facilitate enrollment transactions from CMS to the issuer for enrollees in an individual market Exchange who have not actively selected a different QHP or terminated their coverage during Open Enrollment. Please refer to the 2018 Letter to Issuers for more information regarding submission

[23] SBE-FPs should not transfer off-Exchange SADPs.

requirements pertinent to the Plan ID Crosswalk.[24]

Additionally, please refer to the 2024 Letter to Issuers for more information on two policies that took effect starting plan year 2024.[25] Specifically, CMS finalized a requirement for Exchanges to take into account network similarity to enrollees' current year plan when auto re-enrolling enrollees whose QHPs are no longer available to them, and the "bronze to silver crosswalk policy," which allows an Exchange to direct re-enrollment for bronze plan enrollees who are eligible for cost-sharing reductions (CSRs) in accordance with § 155.305(g) to a silver QHP with a lower or equivalent premium after advance premium tax credits (APTC) within the same product and with the same provider network as the bronze QHP into which they would otherwise have been re-enrolled. The 2024 Letter to Issuers also discusses how the bronze to silver crosswalk policy applies to cross-issuer enrollments, sometimes referred to as alternate enrollments, based on the applicable section of the Federally-facilitated Exchange (FFE) Enrollment Manual.[26]

In the final 2025 Payment Notice, we finalized a policy to require Exchanges to re-enroll enrollees in catastrophic coverage as defined in section 1302(e) of the ACA, including those who will lose eligibility for catastrophic coverage or whose current plan will no longer be available, into a new QHP for the coming plan year, to the extent permitted by applicable State law. CMS generally already re-enrolls these enrollees in Exchanges on the Federal platform, but explicitly incorporating catastrophic plan enrollees into the rules at § 155.335(j) will help ensure continuity of coverage in cases where the issuer does not offer the catastrophic plan for the subsequent plan year, and these enrollees do not actively select a different QHP or terminate their coverage. We also added a new paragraph § 155.335(j)(5) to establish that an Exchange may not newly auto re-enroll an enrollee into catastrophic coverage who is currently enrolled in coverage of a metal level (a non-catastrophic plan) as defined in section 1302(d) of the ACA, consistent with the practice of the Exchanges on the Federal platform.

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 2025 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for SADPs.

### *Section 6. Value-based Insurance Design*

The approach for 2026 remains unchanged from 2021 and later years. Please refer to the 2021 Letter to Issuers for more information.

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[24] *See* Chapter 1, Section 3 of the 2018 Letter to Issuers in the Federally-facilitated Marketplaces, *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.

[25] *See* Chapter 1, Section 5 of the 2024 Letter to Issuers in the Federally-facilitated Exchanges, *available at:* https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf.

[26] *See* Section 3.2.4 of the Federally-facilitated Exchange (FFE) Enrollment Manual, *available at:* https://www.cms.gov/files/document/ffe-enrollment-manual-2023-5cr-071323.pdf.

### *Section 7. Alternative Payment Models (APMs)*

The approach for 2026 remains unchanged from 2022 and later years. 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 2026 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

### *Section 9. Standardized Plan Options*

The approach to standardized plan options for 2026 remains in large part unchanged from the approach in previous years. Please refer to the 2023 and 2024 Letters to Issuers for a summary of these approaches.

However, there are several differences between the approach for 2026 and the approaches in previous years. For 2026, CMS finalized several minor updates to the plan designs to ensure these standardized plan options continue to have actuarial values (AVs) within the permissible AV *de minimis* range for each metal level. Refer to the preamble for 45 CFR 156.201 in the final 2026 Payment Notice for the finalized plan designs.

We amended § 156.201 to add paragraph (c) to require that an issuer that offers multiple standardized plan options within the same product network type, metal level, and service area must meaningfully differentiate these plans from one another in terms of included benefits, provider networks, included prescription drugs, or a combination of some or all these factors, for the 2026 plan year and subsequent years. For the purposes of this standard, a standardized plan option with a different product ID, provider network ID, drug list ID, or a combination of some or all these factors, would be considered meaningfully different.

If an issuer submits two standardized plan options within the same product network type, metal level, and service area with the same product, provider network, and drug list IDs, we will not certify both of these plans. Assuming the issuer meets all other certification requirements, we will seek feedback from the issuer regarding which plan to certify.

### *Section 10. Non-Standardized Plan Option Limits*

The approach to non-standardized plan option limits and to non-standardized plan option limit exceptions for 2026 maintains a high degree of continuity from the approach in previous years. Please refer to the 2024 and 2025 Letters to Issuers for a summary of these requirements.

In the final 2024 Payment Notice, we finalized requirements under 45 CFR 156.202(b) that a QHP issuer in an FFE or an SBE-FP, for the 2025 plan year and subsequent plan years, was limited to offering two non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in § 156.202(c)), in any service area.

However, as we explained in the 2025 Letter to Issuers, issuers have the flexibility to vary the inclusion of dental and/or vision benefit coverage described in § 156.202(c) (including varying the inclusion of the distinct adult and pediatric dental benefit coverage categories) such that issuers could offer plans in the manner demonstrated in the table included in both the final 2025 Payment Notice and Letter to Issuers (and below), instead of in the more limited manner reflected in the incomplete example in the final 2024 Payment Notice.

**Table 1.2 Non-Standardized Plan Options: Example of plan designs permitted within the Plan Limit**

| Plan | Network Type | Cost Sharing Structure | Adult Dental | Pediatric Dental | Adult Vision |
|---|---|---|---|---|---|
| 1 | HMO | A | Not Covered | Not Covered | Not Covered |
| 2 | HMO | A | Covered | Not Covered | Not Covered |
| 3 | HMO | A | Not Covered | Covered | Not Covered |
| 4 | HMO | A | Not Covered | Not Covered | Covered |
| 5 | HMO | A | Not Covered | Covered | Covered |
| 6 | HMO | A | Covered | Not Covered | Covered |
| 7 | HMO | A | Covered | Covered | Not Covered |
| 8 | HMO | A | Covered | Covered | Covered |
| 9 | HMO | B | Not Covered | Not Covered | Not Covered |
| 10 | HMO | B | Covered | Not Covered | Not Covered |
| 11 | HMO | B | Not Covered | Covered | Not Covered |
| 12 | HMO | B | Not Covered | Not Covered | Covered |
| 13 | HMO | B | Not Covered | Covered | Covered |
| 14 | HMO | B | Covered | Not Covered | Covered |
| 15 | HMO | B | Covered | Covered | Not Covered |
| 16 | HMO | B | Covered | Covered | Covered |
| 17 | PPO | C | Not Covered | Not Covered | Not Covered |
| 18 | PPO | C | Covered | Not Covered | Not Covered |
| 19 | PPO | C | Not Covered | Covered | Not Covered |
| 20 | PPO | C | Not Covered | Not Covered | Covered |
| 21 | PPO | C | Not Covered | Covered | Covered |
| 22 | PPO | C | Covered | Not Covered | Covered |
| 23 | PPO | C | Covered | Covered | Not Covered |
| 24 | PPO | C | Covered | Covered | Covered |
| 25 | PPO | D | Not Covered | Not Covered | Not Covered |
| 26 | PPO | D | Covered | Not Covered | Not Covered |
| 27 | PPO | D | Not Covered | Covered | Not Covered |
| 28 | PPO | D | Not Covered | Not Covered | Covered |
| 29 | PPO | D | Not Covered | Covered | Covered |
| 30 | PPO | D | Covered | Not Covered | Covered |
| 31 | PPO | D | Covered | Covered | Not Covered |
| 32 | PPO | D | Covered | Covered | Covered |

In the final 2026 Payment Notice, we modified 45 CFR 156.202(b) to properly reflect the flexibility that issuers have to vary the inclusion of the distinct adult and pediatric dental benefit coverage categories. Specifically, we amended 45 CFR 156.202(b) to state that a QHP issuer in

an FFE or a SBE-FP, for the 2025 plan year and subsequent plan years, is limited to offering two non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs (c)(1) through (3) of § 156.202),[27] in any service area.

We finalized a similar conforming amendment to the non-standardized plan option limit exceptions provision at § 156.202(d) to provide that, for the 2025 plan year and subsequent years, an issuer may offer additional non-standardized plan options for each product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs (c)(1) through (3) of § 156.202), and service area if it demonstrates that these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area.

### *Section 11. Requests for Reconsideration of a Denial of Certification*

Pursuant to 45 CFR 155.1090, the FFEs permit an issuer that has submitted a complete application to an FFE for certification of a health plan as a QHP and is denied certification to request reconsideration of such action. An issuer submitting a request for reconsideration must submit a written request for reconsideration to HHS, in the form and manner specified by HHS, within 7 calendar days of the date of the written notice of denial of certification. The issuer must include any and all documentation the issuer wishes to provide in support of its request with its request for reconsideration. We finalized in the final 2026 Payment Notice that for HHS' denial decision to be overturned, a request for reconsideration must provide clear and convincing evidence that HHS' determination that the plan does not meet the general certification criteria at § 155.1000(c) was in error.

## 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, 156.1105-1130, and 156.1250.)

[27] In the final 2026 Payment Notice, we modified the language at both § 156.202(b) and (d) to state that issuers may vary the inclusion of adult dental benefit coverage, pediatric dental benefit coverage, *and* adult vision benefit coverage, instead of adult dental benefit coverage, pediatric dental benefit coverage, *and/or* adult vision benefit coverage – to enhance clarity and minimize risk of confusion.

This chapter provides an overview of key QHP certification standards for QHPs, including SADPs, in FFEs, including those in States performing plan management functions, and how CMS or the State will evaluate and conduct reviews of 2026 QHPs, including 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.[28] 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. Please refer to the 2023 Letter to Issuers for more information. 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 forthcoming final Plan Year 2026 QHP Data Submission and Certification Timeline, 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 2026 plan year and subsequent plan years. 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 2026 plan year and subsequent plan years, CMS will continue requiring QHPs to use a provider network with the limited exception for SADP issuers defined at 45 CFR 156.230(a)(4). CMS will evaluate QHPs for compliance with network adequacy standards based on time and distance standards and appointment wait time standards. Additionally, 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,

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[28] *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-Certifcation-Reviews-Guidance-41317.pdf.

eliminate duplicative requirements or reviews, and reduce stakeholder burden.

**i. Network Adequacy for QHP Issuers in FFEs**

*a. Time and Distance Standards*

The time and distance standards remain unchanged from 2025. The time and distance standards include two components that issuers must meet – a time component and a distance component. However, CMS has invested in technological advancements to enhance the methodology for assessing issuer compliance with the time and distance standards by improving the accuracy of driving distance estimates, which will help reduce the burden on issuers as CMS is able to identify with greater precision the network gaps requiring attention. The current methodology calculates estimated driving time and distance between Marketplace-eligible consumers (as reflected in the QHP Population Sample File) and servicing provider locations (provided by issuers via their Network Adequacy Template).[29] Street addresses for consumers (based on census data sampling) and providers are assigned latitude and longitude geocodes. Once those coordinates are created, estimated driving time and distance are calculated between consumers and providers. Time is calculated using estimated distance and applying a driving speed based on the geographic area. Distance is measured by determining the estimated driving distance between the geocodes and the average number of Marketplace-eligible consumers in the designated geographic area. The results are compared against the time and distance metric standards for the respective provider specialty type and county type designation to determine if the time and distance standards are met.

In reviewing issuer network adequacy justifications in 2023, CMS identified a need to improve the accuracy of driving distance estimates, to more accurately account for real-life driving conditions experienced by consumers when traveling to access care. CMS is therefore updating its distance calculation methodology to utilize geographic distance instead of estimated driving distance for the 2026 plan year. A geographic distance calculation considers topographic factors that consumers experience when traveling to access care. Examples include infrastructure, rivers, swampland, large bodies of water, and mountainous terrain. The algorithm identifies the most optimal route based on the available infrastructure. CMS believes the optimal route is the most likely way a consumer would travel to a given appointment based on the topographic considerations for the specific service area, and that optimal route is based on distance, travel time, and directness. Customizing topography in service areas will allow CMS to modify current time and distance standards for each of our network adequacy specialty types based on real-world driving conditions instead of driving distance estimates. Using a geographic method that reflects more realistic driving standards will replace the current estimated driving distance approach and, therefore, the driving time and distance expectations to which CMS currently holds issuers. Issuers will benefit from more accurate justifications so they can focus on more precise identification of network gaps. These improvements will reduce the issuer burden of

[29] See Network Adequacy Frequently Asked Question Q5 and Q16 *available at*: https://www.qhpcertification.cms.gov/s/Network%20Adequacy%20FAQs.

submitting network adequacy justifications for each review round. The updated methodology related to network adequacy will consider geographic concerns regarding deficient specialty types, making time and distance reviews more accurately reflective of what consumers are experiencing and requiring issuers to provide less additional justification work when not meeting the standards due to barriers beyond an issuer's control (such as provider supply shortages).

*Telehealth for Time and Distance Standards*

The approach for telehealth services for time and distance standards in 2026 remains unchanged from 2023 and later years. Please refer to the 2023 Letter to Issuers for more information. As noted in the preamble to the final 2025 Payment Notice, we want to ensure that the availability of telehealth services do not reduce the availability of in-person care. We explained that more research would be needed before we could analyze whether counting telehealth is appropriate for purposes of a QHP meeting network adequacy time and distance standards. Because time and distance standards are a metric related to physical access, taking telehealth into account in measuring that metric is complex.

*b. Appointment Wait Times*

The approach for appointment wait time standards remains unchanged from 2025 with a technical correction noted in italics below. Please refer to the 2025 Letter to Issuers for more information. Medical QHP issuers in the FFEs are subject to secret shopper survey requirements explained more fully in the *Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs).*[30] As we stated in the 2025 Letter to Issuers, issuers that fail to have a third-party entity conduct the secret shopper survey, fail to report the results, or report results that do not reflect compliance with the appointment wait time standards would need to add more contracted providers to their network *and/or come into alignment with the standards by contracting with a third-party entity to conduct the surveys and reporting compliant results, as appropriate.*

**ii. Network Adequacy Justification Process**

For the 2026 plan year, if an issuer's application does not satisfy the network adequacy standard, an issuer is required to include a satisfactory justification as part of its application for QHP certification. However, as noted above, an issuer should not use the Network Adequacy Justification Form[31] to report an issuer's failure to contract with a third party to administer the secret shopper provider surveys. The justification process remains unchanged from the 2025 plan year. CMS will only accept the official Network Adequacy Justification Form, which is a

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[30] *See* Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs), *available at:* https://www.qhpcertification.cms.gov/s/AWT-SSS-Tech-Guide-QHP-FFE-508.pdf?v=1.

[31] *See* information collection request, CMS-10803, "Essential Community Provider-Network Adequacy (ECP/NA) Data Collection to Support QHP Certification," under the Paperwork Reduction Act (PRA) for reference. CMS submitted this information collection request to OMB for an additional 3-year collection period. This updated information collection request is pending OMB approval at the time of release of this 2026 Final Letter, and covers data collected for the 2026 plan year.

partially prepopulated Excel document. CMS will review any updated provider data submitted on the issuer's Network Adequacy Template and completed Network Adequacy Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirements relating to network adequacy 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 Form. This will ensure that CMS is aware of the potential barrier(s) so that CMS can weigh the barrier(s) in determining whether to grant an exception under § 156.230(a)(3). CMS expects such issuers to demonstrate to CMS via their Network Adequacy Justification Form 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.

CMS now will allow the family medicine physician provider type to count toward satisfaction of the "Primary Care – Pediatric" specialty type and the "Primary Care – Adult" specialty type in all county type designation areas.

For plan years 2023 through 2025, CMS allowed advanced practice registered nurses (APRNs) and physician assistants (PAs) to satisfy the "Primary Care – Pediatric" and "Primary Care – Adult" specialty type only if the providers were rendering services to enrollees in Health Professional Shortage Areas (HPSAs). Starting in the 2026 plan year, CMS will allow APRNs and PAs to satisfy the "Primary Care – Pediatric" and "Primary Care – Adult" specialty types in all areas rather than limiting credit to only Health Professional Shortage Areas (HPSAs). Furthermore, CMS will allow APRNs who specialize in behavioral health services to satisfy the outpatient clinical behavioral health provider category in all areas.

**iii. Network Transparency**

The approach for network transparency for 2026 remains unchanged from 2023 and later years. 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 essential community providers (ECPs) in provider networks, which require that issuers include at least a

certain threshold percentage, as determined by 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). Please refer to the 2024 Letter to Issuers for full details of the ECP standards. The ECP standard for the 2026 plan year will remain the same as for the 2024 plan year, however, we finalized in the final 2026 Payment Notice to conduct ECP reviews for all FFE issuers, including FFE QHP issuers in States performing plan management functions effective beginning in the 2026 plan year, consistent with our statutory authority under Section 1311(c)(1)(C) of the ACA.

CMS has relied on State ECP certification reviews for the certification of QHPs in FFEs in States that perform plan management functions since the 2015 plan year due to system limitations in the Systems for Electronic Rates & Forms Filing (SERFF).[32] From plan year 2015 to 2024, prior to CMS' implementation of the user interface for ECPs in the Marketplace Plan Management System (MPMS),[33] FFE issuers in States performing plan management functions would submit their ECP data to CMS via transfers from SERFF templates and binders; this created limitations for CMS because there were no reliable mechanisms to convert the ECP data received from SERFF to CMS. The SERFF data do not have unique network and service area IDs needed for CMS to reliably associate with the issuer's ECP data for network evaluation. As a workaround to this limitation, CMS merged the SERFF data across each issuer's plan and removed duplicate entries to allow CMS to conduct the review at the plan level. While this workaround allowed CMS to conduct the ECP reviews at the plan level, it did not allow CMS to distinguish between multiple networks that share the same sequence number, which hindered CMS from consistently conducting independent ECP evaluations of each issuer's network within the SERFF data. CMS will be conducting ECP reviews of all FFE QHP issuers, including in States performing plan management functions, due to system enhancements in MPMS for the 2025 plan year. MPMS now allows FFE issuers in States performing plan management functions to submit ECP data directly to CMS instead of relying on SERFF data transfers, enabling CMS to conduct ECP evaluations of each issuer's network. In addition, the enhanced MPMS allows FFE issuers in States performing plan management functions to validate their ECP data before submission to their State(s) in SERFF, which improves data submission to the State(s) as well. MPMS allows CMS the technical capability to review the validated ECP data for issuers in States performing plan management functions. This significantly improves the accuracy and efficiency of the ECP QHP certification process for all FFE QHP issuers, including QHP issuers in States performing plan management functions.

This approach provides consistent oversight of ECP data across all FFEs and allows CMS to review, evaluate, analyze, and compare provider networks across various FFE States. Issuers applying for certification of plans as QHPs in FFE States performing plan management functions will be evaluated against the same ECP standards as issuers in FFE States not performing plan

[32] Systems for Electronic Rates & Forms Filing (SERFF) is a portal utilized by States for form submittal, document management, and review access.

[33] MPMS is a web application where issuers can validate plan data and submit QHP certification applications to CMS as part of the certification process.

management functions. ECP reviews by CMS in FFEs in States performing plan management functions strengthen ECP oversight and ensure all medical QHP and SADP issuers applying for certification to offer QHPs in the FFEs include compliant provider networks.

### *Section 5. Accreditation*

The approach for reviews of the accreditation standard remains largely unchanged from 2020 and later years. 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. 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 is continuing to assess patient safety standards and any related burden for issuers, providers, and hospitals.

### *Section 7. Quality Reporting*

The approach for QHP certification reviews 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 2025[34] for more detailed information on issuer data collection and reporting requirements for the 2025 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 2026 plan year.

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

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[34] *See* Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2025 (September 2024), *available at:* https://www.cms.gov/files/document/qrs-and-qhp-enrollee-experience-survey-technical-guidance-2025.pdf.

### *Section 9. Review of Rates and Forms*

The approach for reviewing rate filings for the 2026 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.[35]

Issuers in States with an Effective Rate Review Program that use SERFF are able to comply with the requirement to submit rate filing justifications to CMS by submitting the rate filing directly in SERFF. 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 the upload is successful.[36] This functionality does not apply to States that do not have an Effective Rate Review Program[37] and States that do not participate in SERFF. Issuers in those States will need to continue to submit the rate filing justification 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 with an Effective Rate Review Program's reviews of issuer-submitted rate filings for reasonableness and compliance with market-wide standards as part of CMS' QHP certification process, provided that States complete the reviews in a manner consistent with FFE operational timelines. States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.[38] Similarly, CMS, as part of its QHP certification process, will rely on States' reviews of issuer-submitted policy forms for compliance with Federal laws and regulations for which the State has enforcement authority, provided that States complete the reviews in a manner consistent with FFE operational timelines. Issuers in States that do not review policy forms for compliance with all applicable Federal requirements should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.[39] These issuers will have to submit two sets of policy form filings. One filing will be submitted to the State through the State instance of SERFF or in the manner specified by the State, and the second filing will be submitted to CMS through the CMS instance of SERFF.[40]

### *Section 10. Discriminatory Benefit Design*

CMS' approach to enforcement of discriminatory benefit design requirements generally remains the same as outlined in the Letter to Issuers from 2017 and subsequent years. Specifically, to ensure robust consumer protection against potentially discriminatory benefit designs, CMS will

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[35] *See, e.g.*, the Unified Rate Review Instructions, *available at*: https://www.cms.gov/files/document/urr-py23-instructions.pdf.
[36] Ibid.
[37] See *supra* note 18.
[38] See *supra* note 19.
[39] See *supra* note 21.
[40] 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."

continue to review plan benefit designs to ensure they are nondiscriminatory and align with 45 CFR 156.125. CMS also coordinates with States to ensure that QHPs in the FFEs adhere to the EHB nondiscrimination policy. While enforcement of EHB policy primarily falls on the States, CMS will continue to monitor issuer compliance, provide technical assistance, and share relevant data and research.

### *Section 11. Prescription Drugs*

CMS will continue conducting an adverse tiering review as one of the prescription drug reviews.[41] The adverse tiering review assesses whether submitted formularies associate higher cost sharing to all or a majority of drugs needed to treat certain chronic medical condition(s). For the 2026 plan year, the following medical conditions are included in the adverse tiering review: hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis. Plans will be flagged for possible adverse tiering if all drugs for at least one of the four medical conditions are placed on the highest effective cost sharing tier. Drugs and drug classes in each condition under review are Food and Drug Administration (FDA) approved drug therapies, as recommended by nationally recognized clinical guidelines.

### *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*

CMS will conduct Cost-sharing Reduction Plan Variations review of QHP Application templates as done in previous plan years. Eligible consumers can enroll in these plan variations for the 2026 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*

CMS will conduct data integrity reviews of QHP application templates as done in previous plan years. The review will identify data errors that would result in improper display of plan information to consumers as well as other template irregularities. CMS may choose to conduct outreach throughout QHP Certification with issuers that have unresolved data integrity errors.

### *Section 15. Requirements for Plan Marketing Names*

CMS will conduct reviews of QHP plan and plan variation marketing names to ensure they include correct information, without omission of material fact, and do not include content that is

[41] Formulary reviews include: Non-Discrimination (ND) Clinical Appropriateness, ND Formulary Outlier, and ND Treatment Protocol Calculator.

misleading.[42] More information about this review is available in the 2024 Letter to Issuers and the Plan Marketing Name Fact Sheet, and slides from the June 6, 2024 QHP Certification Webinar.[43]

### *Section 16. Interoperability*

For the 2026 plan year, requirements for the interoperability QHP Certification review have not changed. More information on this review can be found in the 2024 Letter to Issuers.[44] However, note that in February 2024 CMS published the Advancing Interoperability and Improving Prior Authorization Processes Final Rule, which established additional requirements that will apply in future plan years.[45] Issuers can refer to that Final Rule and related technical assistance materials to learn more about these requirements, several of which will take effect in plan year 2026 related to publicly reporting certain information from plan year 2025.

## 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.

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[42] 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 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).

[43] *See* Chapter 2, Section 15 of the 2024 Final Letter to Issuers in the Federally-facilitated Exchanges, *available at*: https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf. *See also* Plan Marketing Name Fact Sheet, *available at*: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits (scroll to "Plan Marketing Name Fact Sheet"). Also *see* the June 6, 2024 QHP Certification Webinar slides, *available at*: https://regtap.cms.gov/reg_librarye.php?i=5407, and the webinar recording, *available at*: https://regtap.cms.gov/reg_librarye.php?i=5418&type=v.

[44] *See* Chapter 2, Section 16 of the 2024 Final Letter to Issuers in the Federally-facilitated Exchanges, *available at:* https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf.

[45] *See* the Advancing Interoperability and Improving Prior Authorization Processes Final Rule, which *available at*: https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability. A fact sheet on the final rule is *available at:* https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.

### *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 (OMB Control Number 0938-1310) was approved on April 12, 2022. The data elements issuers must report for the 2026 plan year are unchanged from those collected as part of QHP certification for the 2024 and 2025 plan years. Issuers must provide both their Transparency in Coverage data and their Transparency in Coverage URL submissions via the MPMS module in HIOS. CMS is continuing to explore other ways to enhance the accuracy of these data, including whether to use these data for compliance purposes in future plan years.

### *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: 2026 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 2025. Please refer to the 2018 through 2025 Letters to Issuers for more information.

### *Section 1. SADP Annual Limitation on Cost Sharing*

For the 2026 plan year, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 28.863 percentage point increase in the Consumer Price Index (CPI) for dental services of 590.616 for 2024 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $101.02 to a total of $451.02. 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 2026 plan year will be $450 for one child and $900 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 (AV) Requirements*

The approach to AV requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021 and later years. Please refer to the 2021 Letter to Issuers for more

information. Starting with the 2024 plan year, SADP issuers may offer the pediatric dental EHB at any AV. SADP issuers are required to certify the AV of each SADP's coverage of pediatric dental EHB.

Additionally, beginning with the 2024 plan year, SADP issuers applying for QHP certification are no longer required to submit a separate SADP attestation form and instead attest to compliance with applicable standards as part of the general program attestation. Please note the requirement in 45 CFR 156.150(b)(2) that an SADP must have the plan's AV of coverage for pediatric dental EHB certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and reported to the Exchange is still applicable, and submitting the general program attestation includes attesting to compliance with this requirement.

### *Section 3. SADP Age on Effective Date Methodology Requirement*

Guidance on the requirement for SADP issuers 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 remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

### *Section 4. SADP Guaranteed Rates Requirement*

Guidance on the requirement for SADP issuers to submit guaranteed rates remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

## 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 CFR 147.104(e), 45 CFR 155.201, 155.220, 155.221, and 155.1010, and 45 CFR 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 Information Regarding the Registration Completion List and Health Line of Authority Check*

The approach for 2026 remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

CMS intends to continue to work with States as well as QHP issuers to monitor the activities of agents and brokers participating in the FFEs and SBE-FPs, and prevent fraud, waste, and abuse.

### *Section 2. FFE Oversight of Agents and Brokers*

The approach for 2026 remains largely unchanged from 2018. Please refer to Chapter 5, Section

4. FFE Oversight of Agents and Brokers of the 2018 Letter to Issuers for more information.

**i. Monitoring and Oversight**

As in prior years, CMS will continue to work with States to coordinate oversight activities related to agents and brokers registered with the FFEs.[46] CMS may investigate complaints pertaining to agents and brokers in the FFEs and SBE-FPs, and will monitor QHP issuer activities to confirm they are meeting their responsibilities for oversight of affiliated agents and brokers. Agents and brokers registered with the FFEs, including those participating in SBE-FPs, must comply with all applicable privacy and security requirements, and execute the IM Privacy and Security Agreement and/or the SHOP Privacy and Security Agreement (depending on whether the agent or broker is participating in the FFEs or SBE-FPs for the individual market, the FF-SHOP/SBE-FP-SHOP, or both), which includes further details on the Marketplace privacy and security standards related to the use and disclosure of personally identifiable information (PII).

CMS may terminate an agent's or broker's agreement(s) with CMS (Exchange agreements) for cause if it determines that a specific finding of noncompliance or a pattern of noncompliance is sufficiently severe (based on which Federal standards have been violated, and factors such as financial impact and number of consumers affected), or if the agent or broker breaches any term or condition of the General Agreement, IM Privacy and Security Agreement, SHOP Privacy and Security Agreement, and/or the Web-Broker Agreement, as applicable, among other reasons.[47] States, QHP issuers,[48] as well as members of the public can review CMS' Registration Completion List (RCL) to see the National Producer Numbers (NPNs) of agents and brokers who registered with the FFEs[49] for a given plan year, as well as the Registration Termination List to see the NPNs of agents and brokers whose Exchange agreements and registration have been suspended or terminated by CMS, or who have voluntarily terminated their Exchange agreements and registration.[50] The RCL also includes an end date which reflects the expiration date of the agent's or broker's Exchange agreements or the suspension/termination date of the agreements, whichever date is earlier.[51]

We note that termination of an agent or broker's Exchange agreement(s) results in termination of

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[46] Agents and brokers registered with the FFEs may also participate in the SBE-FPs if they maintain the appropriate license under State law and comply with other applicable requirements. *See* 45 CFR 155.220(l).
[47] 45 CFR 155.220(g).
[48] QHP issuers maintain responsibility for their compliance and the compliance of any of their delegated or downstream entities with all applicable Federal standards related to the Exchanges. *See* 45 CFR 156.340. For QHP issuers participating in FFEs and SBE-FPs, this includes but is not limited to being responsible for their affiliated agents' and brokers' compliance with the standards of § 155.220. *See* 45 CFR 156.340(a)(2).
[49] See *supra* note 46.
[50] The Registration Completion List and Registration Suspension and Termination List can be accessed at https://data.healthcare.gov/ffm_ab_registration_lists.
[51] The Registration Completion List includes the dates that the Exchange agreements expire ("registration end dates") for reference. For example, the 2023 Exchange agreements expired on October 31, 2023, and the 2024 Exchange agreements expired on October 31, 2024.

FFE registration for the plan year during which the termination became effective, which results in the following:

- Adding the agent's or broker's NPN to the Registration Termination List,
- Changing the registration end date on the RCL, and
- Removal of the agent/broker role from FFE user credentials through the CMS Identity Management (IDM) system, which prevents the agent or broker from logging into the agent/broker landing page on a QHP issuer or web-broker website for direct enrollment.

Termination of an agent or broker's Exchange agreement(s) bars the agent or broker from actively assisting with new enrollments through the FFEs or SBE-FPs for the remainder of the plan year and from being compensated by QHP issuers for any specific enrollments connected to the agent's or broker's noncompliance that formed the basis of the termination.[52] If an agent's or broker's Exchange agreement(s) are terminated (either by the agent or broker or by CMS), the agent or broker must continue to protect any PII that was accessed during the term of his or her Exchange agreement(s) in accordance with the IM and/or SHOP Privacy/Security Agreement and the applicable requirements under 45 CFR 155.260.[53]

Under 45 CFR 155.220(g)(5), CMS may suspend the agent's or broker's agreement(s) for up to 90 calendar days if it reasonably suspects that an agent or broker may have engaged in fraud or abusive conduct that may result in imminent or ongoing consumer harm using PII of FFE or SBE-FP applicants or enrollees, or in connection with an FFE or SBE-FP enrollment or application.[54] CMS may immediately terminate the agent's or broker's Exchange agreement(s) with CMS for cause if there is a finding or determination by a Federal or State entity that an agent or broker engaged in fraud or abusive conduct, parallel to the suspension provision.[55] Agents and brokers whose Exchange agreement(s) are suspended or immediately terminated in these circumstances may submit evidence to rebut the allegation, as described in §155.220(g)(5)(i)(B) in the case of suspension or §155.220(h) in the case of immediate termination. During the suspension period[56] and following immediate termination of the Exchange agreement(s), the agent or broker will not be registered with the FFEs, or be permitted to facilitate enrollments through an FFE or SBE-FP, or be permitted to assist individuals with applying for advance payments of the premium tax credit (APTC) or CSRs.

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[52] See 45 CFR 155.220(d), (g)(4), (g)(5)(iii), (j)(1), (l); 45 CFR 156.340(a)(2) (a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities with all applicable Federal standards related to Exchanges).

[53] 45 CFR 155.220(g)(4), (g)(5)(iii).

[54] 45 CFR 155.220(g)(5)(i)(A).

[55] 45 CFR 155.220(g)(5)(ii).

[56] Suspensions under 45 CFR 155.220(g)(5)(i)(A) are based on HHS' reasonable suspicion that the agent, broker, or web-broker may have engaged in fraud or in abusive conduct and do not constitute final agency action or a finding of noncompliance by the agent or broker. In addition, a CMS decision to suspend or terminate an agent, broker, or web-broker's Exchange agreements under 45 C.F.R. § 155.220(g) is not a final agency action. Agents, brokers, and web-brokers subject to these enforcement actions are entitled to rebuttal and reconsideration review periods under 45 C.F.R. § 155.220(g) and (h).

Effective as of the date of the notice of Exchange agreement suspension or termination, CMS will add the NPN of the agent or broker to the Registration Termination List, change the 'registration end date' on the RCL, and disable the agent/broker role from the FFE user credentials through the IDM system. If the suspension is lifted or the termination is overturned after reconsideration, the RCL and Registration Termination List will be updated to reflect the end date of the suspension, or the reconsideration of the termination, and the agent/broker role will be restored through the IDM system.

CMS notifies the State Department of Insurance (DOI) or equivalent State producer licensing authority in cases of suspensions or terminations of the agent's or broker's Exchange agreements and registration with an FFE effectuated under §155.220(g).[57] CMS will also coordinate with impacted QHP issuers to the extent that it will not impede any State or Federal law enforcement investigation and as otherwise permitted under applicable Federal or State law. CMS currently works with States and law enforcement to investigate and resolve suspected incidents of fraud or abusive conduct, and we will continue to coordinate with State and Federal agencies (including law enforcement) if CMS were to suspend or terminate an agent's or broker's Exchange Agreements, as appropriate. QHP issuers who suspect that an agent, broker, or web-broker is engaging in fraudulent or abusive conduct related to enrollments through the FFEs or SBE-FPs should report the incident or activity to their CMS Account Managers, as well as the applicable State DOI(s) or equivalent State producer licensing authority(ies).

CMS may, using its authority under 45 CFR 155.220(k), take other appropriate enforcement actions, which could include the denial of the right for the agent or broker to enter into an Exchange agreement(s) with CMS in future years and/or the pursuit of civil money penalties under 45 CFR 155.285. As described at §155.220(k)(1)(i), CMS has the authority to bar agents and brokers from entering into Exchange agreements with CMS in future plan years. We interpret this authority to allow CMS to terminate an agent or broker's current plan year Exchange agreement(s) for a violation that occurred in a previous plan year, but was only discovered after that plan year's Exchange agreement(s) had expired.[58] If an agent or broker has been barred from entering into Exchange agreements with CMS,[59] the agent or broker's NPN will appear on the Registration Termination List for the impacted plan years. Unless the agent or broker is barred from entering into Exchange agreements with CMS in future plan years, an agent or broker whose Exchange agreements and registration CMS has terminated in one plan year may register with the FFEs[60] and enter into Exchange agreements with CMS in future plan years.

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[57] 45 CFR 155.220(g)(6).
[58] See 45 CFR 155.220(k)(1)(i).
[59] Agents and brokers who are denied the right to enter into Exchange agreements with CMS in future plan years cannot complete the FFE registration process or those plan years and are barred from assisting consumers with enrollments in FFEs and SBE-FPs during this time.
[60] See *supra* note 46.

### ii. Compensation

This section describes QHP issuer agent and broker compensation standards that reflect the same approach as 2017, with some clarifications. QHP issuers directly compensate their affiliated agents and brokers for assisting consumers enrolling in coverage through an FFE or SBE-FP under the terms of the contracts between the QHP issuer and their agents and brokers. Compensation includes commissions, fees, or other incentives (whether monetary or non-monetary) related to enrollment or renewal in FFE or SBE-FP coverage as established in the relevant contract between a QHP issuer and the agent or broker. An agent or broker must be affiliated or have a contractual relationship with the respective issuer, in accordance with applicable State law, and must complete the applicable FFE registration requirements to be eligible to receive compensation from the issuer for a Marketplace transaction.[61]

The FFEs do not set compensation levels or pay commissions or other compensation to agents or brokers.[62] CMS does not require QHP issuers to offer contracts to agents and brokers, including offering compensation for enrollment in QHPs through the FFEs.[63] The FFEs also do not play a role in making appointments between QHP issuers and agents and brokers, and the FFEs are not a party to the contract between the QHP issuer and the agent or broker. QHP issuers should compensate only agents and brokers that were compliant with applicable Federal requirements, including those for registration with the FFEs, at the time they actively assisted a consumer with an FFE or SBE-FP enrollment or renewal and are not required to compensate unaffiliated agents and brokers.[64] CMS believes that withholding compensation from affiliated agents and brokers for a particular QHP enrollment or renewal is appropriate where an agent or broker is found to have been out of compliance with FFE registration or other applicable Federal requirements at the time they actively assisted with the FFE or SBE-FP enrollment or renewal. This would generally be required for a QHP issuer to demonstrate compliance with 45 CFR 156.340 as it relates to oversight of its downstream and delegated entities, which includes affiliated agents and brokers.[65] However, HHS rules governing QHP issuers neither prohibit nor direct a QHP issuer to pay compensation for FFE and SBE-FP enrollments or renewals that were completed prior to the date of the agent's or broker's Exchange agreement suspension or termination.

The FFEs transmit the identifying information of FFE-registered agents and brokers (e.g., NPN)

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[61] See Chapter 5, Section , Subsection vi, "Registration Requirements for Initial Enrollment and Re-enrollment Transactions" of the 2018 Letter to Issuers for information on the one exception to this general rule, 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.

[62] However, as detailed further below, under 45 CFR 156.200(f), a QHP issuer must pay the same agent or broker compensation for QHPs offered through an FFE that it pays for similar health plans offered in the State outside an FFE.

[63] Ibid.

[64] See 45 CFR 156.340 and Chapter 5, Section 4, Subsection i, "QHP Issuer Responsibilities" of the 2018 Letter to Issuers for information on the one exception to this general rule, 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. .

[65] 45 CFR 156.340(a)(2).

to QHP issuers on 834 enrollment transactions (834). In cases where an FFE-registered agent or broker receives compensation through a third-party entity such as an agency or brokerage that is registered with the FFEs, the agent or broker may work with the QHP issuer to appropriately direct compensation based on the NPN included on the 834. The QHP issuer has the discretion to comply with the agent's or broker's request for direction or manner of payment according to the terms of their compensation arrangement and applicable State law.

If an FFE-registered agent or broker has a reason to believe that his or her NPN (or agency/brokerage NPN) should have been included on the 834 but was not, the agent or broker may contact the respective QHP issuer directly to discuss the situation. CMS expects that a QHP issuer would issue compensation to an FFE-registered agent or broker with whom the QHP issuer is affiliated if it is determined from the issuer's, agent's, or broker's records that the agent or broker did in fact assist the consumer, but the NPN was erroneously left off of the 834. Those records may include a consent form from the consumer, an issuer's broker of record form, or similar documentation to demonstrate that the consumer was the agent's or broker's client for the enrollment in question.

Agents and brokers who are acting as Navigators, certified application counselors, and/or (in FFEs, including FFEs where States are performing plan management functions) non-Navigator assistance personnel may not receive any direct or indirect compensation from health insurance or stop loss insurance issuers in connection with the enrollment of any individuals or employees in a QHP or non-QHP.[66]

All agents and brokers should follow State standards with respect to charging consumers directly for services provided, including any requirements for disclosure of the amount being charged directly to the consumer for providing assistance.

Per 45 CFR 156.200(f), a QHP issuer must pay the same agent or broker compensation for QHPs offered through an FFE that it pays for similar health plans offered in the State outside an FFE. We remind issuers that compliance with this rule is a required participation standard for QHP issuers offering coverage in the FFEs, including both the individual market and SHOP. We note that in determining whether a health plan offered in the State outside of the Exchange is similar to a QHP offered through the FFEs, we would consider whether the plan has a similar cost sharing and benefit structure, covers a majority of the same service area, and covers a majority of the same provider network as compared to the QHP.[67] A compensation arrangement in which an issuer pays no commission for sale of a QHP through an FFE, but does pay commission for sale of a similar plan outside of the FFE, would violate the agent and broker compensation standard in § 156.220(f).)

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[66] 45 CFR 155.210(d)(4), 155.215(a)(1)(D) (Navigators)); 155.215(a)(2)(ii)(D) (Non-Navigator assistance personnel); 155.225(g)(2) (certified application counselors).

[67] In making this determination, CMS will consider the same criteria outlined in the market-wide definition of "plan" at 45 CFR 144.103 and the discussion of whether a health plan offered outside the Exchange is "substantially similar" to a QHP in paragraph (3) of the definition of "QHP" set out at 45 CFR 153.500.

### iii. Registration Requirements for Initial Enrollment and Re-enrollment Transactions

Agents or brokers who are assisting consumers with enrollment in QHPs offered through the FFEs and SBE-FPs must meet all applicable State and Federal requirements, including those for State licensure and FFE registration, at the time they are providing active assistance to Marketplace consumers.[68] When assisting a consumer with initial enrollment in a QHP through the FFEs or SBE-FPs, the agent or broker must have an FFE registration for that plan year. In any future plan year, the requirement for FFE registration depends on whether the agent or broker is providing active assistance with updates to the on-Exchange QHP application or enrollment (active re-enrollment), or if the consumer autos re-enrolls, which involves passively renewing or re-enrolling in on-Exchange QHP coverage (whether in the same plan or through the suggested alternative plan mechanism).[69]

- If the agent or broker is actively assisting the consumer to make changes to the on-Exchange QHP application or enrollment, the agent or broker must have an FFE registration for that plan year.
- If the consumer is auto re-enrolled in the same plan or through the suggested alternative plan mechanism, CMS does not require the agent or broker to have an FFE registration for that plan year.[70] Assuming the agent or broker was registered and met all applicable State and Federal requirements at the time of providing active assistance to the consumer with the prior enrollment through the FFE or SBE-FP, CMS rules do not prohibit the QHP issuer from paying compensation for the passive coverage renewal or re-enrollment.

The issuer should use the RCL to verify that the NPN of the agent or broker who is credited for the on-Exchange QHP enrollment was registered at the time of the original enrollment or the active re-enrollment. Although the RCL for plan year 2026 will indicate State licensure status, QHP issuers are responsible for validating the licensure status of their affiliated agents and brokers against State and the NAIC records to confirm an agent or broker's State-level authority to sell health insurance.

## CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

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

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[68] See 45 CFR 155.220(d), (e), (j), and (l).

[69] See "Operational Tips for Agents/Brokers in the Federally-facilitated Marketplaces (FFEs)" (January 22, 2016) available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB_Operational_Tips_01_22_2016.pdf. For information about the required steps for agent and broker FFE registration, see "Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces" (January 8, 2016) available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Role-of-ABs-in-Marketplace-1_6_16.pdf.

[70] Auto re-enrollment, where the consumer is passively renewed or re-enrolled in the same plan or through the suggested alternative plan mechanism, without the agent or broker making changes to the application or enrollment, does not require the associated agent or broker to have an FFE registration for that plan year because the agent or broker has not provided active assistance to the Marketplace consumer during that plan year.

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 from 2018 and later years. As a reminder, in November 2023, the Departments of Labor, HHS, and the Treasury (the Departments) issued updated guidance for plans and issuers subject to the culturally and linguistically appropriate standards set forth in the internal claims and appeals and external review processes under the rules implementing section 2719 of the PHS Act (2023 CLAS Guidance).[71] The Departments also published an FAQ indicating that this guidance is applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2025 and until the next version of this guidance is issued and effective.[72] The Departments intend to update the model notices for internal claims and appeals and external review (with updated taglines in applicable non-English languages) to reflect the updates in the 2023 CLAS Guidance.

### *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 and regulations that require QHP issuers (including SADP issuers) to take reasonable steps to ensure meaningful access by individuals with limited English proficiency (LEP).

The approach to meaningful access generally remains unchanged from 2023 and later years. As a reminder, in November 2023, the Departments issued updated guidance for plans and issuers subject to the culturally and linguistically appropriate standards set forth in the internal claims and appeals and external review processes under the rules implementing section 2719 of the PHS Act and in the summary of benefits and coverage (SBC) and uniform glossary rules implementing section 2715 of the PHS Act (2023 CLAS Guidance).[73] The Departments also published an FAQ indicating that this guidance is applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2025 and until the next version of this guidance is issued and effective.[74] The Departments intend to update the following documents to reflect the updates in the 2023 CLAS Guidance:

- SBC template and sample completed SBCs in English (with updated taglines in applicable non-English languages);

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[71] County Data for Culturally and Linguistically Appropriate Services (November 2023), *available at* https://www.cms.gov/files/document/clas-county-data-2023.pdf.
[72] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), *available at:* https://www.cms.gov/files/document/faqs-part-63.pdf.
[73] See *supra* note 71.
[74] See *supra* note 72.

- Additional translated versions of the SBC and Uniform Glossary; and
- Model notices for internal claims and appeals and external review (with updated taglines in applicable non-English languages).

### *Section 4. Summary of Benefits and Coverage (SBC)*

The guidance on the SBC largely remains unchanged from the 2025 Letter to Issuers. As a reminder, in November 2023, the Departments issued updated guidance for plans and issuers subject to the culturally and linguistically appropriate standards set forth in the summary of benefits and coverage (SBC) and uniform glossary rules implementing section 2715 of the PHS Act.[75] The Departments also published an FAQ indicating that this guidance is applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2025 and until the next version of this guidance is issued and effective.[76] The Departments intend to update the SBC template and sample completed SBCs in English (with updated taglines in applicable non-English languages) and additional translated versions of the SBC and Uniform Glossary to reflect the updates in the 2023 CLAS Guidance.

As a reminder, QHP issuers must follow the SBC Instruction Guide for Individual Health Insurance Coverage[77] for limited and zero cost-sharing plans for American Indians and Alaska Natives (AI/AN), including instructions specific to those variations. This includes the requirement that for AI/AN limited cost-sharing plans, QHP issuers must include a box below the coverage examples with the following language: "Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher." Issuers may find it helpful to refer to the AI/AN limited cost sharing and AI/AN zero cost sharing sample completed SBCs for examples of how to complete SBCs for those variations.[78]

## 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.[79]

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[75] See *supra* note 71.
[76] See *supra* note 72.
[77] Summary of Benefits and Coverage Instruction Guide for Individual Health Insurance Coverage (January 2021), *available at* https://www.cms.gov/files/document/individual-instructions-060723.pdf.
[78] Sample Completed AI/AN Limited Cost Sharing SBC, *available at* https://www.cms.gov/files/document/aian-limited-cost-sharing-060723.pdf; Sample Completed AI/AN Zero Cost Sharing SBC, available at https://www.cms.gov/files/document/aian-zero-cost-sharing-060723.pdf.
[79] 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.