Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

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

Title: 2025 Final Letter to Issuers in the Federally-facilitated Exchanges

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2025 Final Letter to Issuers in the Federally-facilitated Exchanges (2025 Final Letter). This 2025 Final Letter provides updates on operational and technical guidance for the 2025 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 2025 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 2025. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2025 Final Letter focuses on guidance that has been updated for the 2025 plan year, and refers issuers to the 2017 through 2024 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-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.

this 2025 Final Letter apply to the QHP certification process for plan years beginning in 2025.[2] Throughout this 2025 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 2025 Final Letter are to Title 45 of the CFR.[3] While certain parts of the 2025 Final Letter explain associated regulatory requirements, the 2025 Final Letter is not a complete list of regulatory requirements for issuers.

[2] Plan years in the FF-SHOPs will not always align with calendar year 2025.
[3] *Available at:* https://ecfr.federalregister.gov/current/title-45.

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) 2025 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. CMS will review QHP applications for all issuers applying for QHP certification in an FFE[7] and notify issuers of any need for corrections. After the final QHP

[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 2025 Final Letter.
[7] 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

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.[8] 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.[9] 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 2025 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.[10]

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 2025 QHP Data Submission and Certification 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.[11] All issuers must also register for the Plan Management (PM) Community to receive

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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.

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

[9] 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.

[10] 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.

[11] *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 2025 plan year that are the

relevant communications regarding their QHP applications.[12]

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.[13] 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.[14] Issuers submitting applications for QHP Certification in SERFF should work directly with the State to submit all QHP issuer application data in accordance with State guidance.[15]

All issuers applying for QHP certification for the 2025 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 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 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.

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same as plans, including SADPs, certified as QHPs for the 2024 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 2025 plan year if the plan has not changed since the SADP was certified for the 2024 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 2025 plan year that had been certified for the 2024 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

[12] For issuers not currently participating in the PM Community, in spring 2024 CMS intends to make instructions available on how to enroll to receive information for the 2025 plan year QHP application period.

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

[14] 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.

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

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: Add new plans to a QHP application; Change an off-Exchange plan to be both on and off-Exchange; Change plan type(s) or market type; or Change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan.

	Permitted with No State or CMS Authorization Required	Permitted with Authorization*	Not Permitted
After the Final Submission Deadline	N/A	Issuers may request critical data changes to align with State filings. 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 the Limited Data Correction Window, may be subject to compliance action by CMS.[16] Issuer changes made in the Limited Data Correction Window not approved by CMS and/or the State may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After completion of the QHP certification process, CMS may offer additional data correction windows. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the State or CMS. CMS will offer windows for SHOP quarterly rate updates for issuers in an FF-SHOP. 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.

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

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.[17] States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.[18] 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.[19] 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.[20]

When States perform QHP certification reviews,[21] they may exercise reasonable flexibility in

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[17] CMS will be responsible for reviewing the 2025 plan year rate filings in two States that do not have an Effective Rate Review Program (Oklahoma and Wyoming).

[18] See *Bulletin: Timing of Submission of Rate Filing Justifications for the 2024 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2025* that will be available at https://www.cms.gov/marketplace/resources/regulations-guidance#Review-of-Insurance-Rates.

[19] 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, 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, 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.

[20] 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 2025.

[21] 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.

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

CMS expects that States will establish the timeline, communication process, and resubmission window for any reviews conducted under State authority. As noted previously, issuers should comply with any State-specific guidelines for review and resubmission related to State review standards. CMS notes that issuers may be required to submit data to State regulators in addition to what is required for QHP certification through the FFEs, if required by a State, and must comply with any requests for resubmissions from the State or from CMS in order to be certified. CMS will seek to coordinate with States so that any State-specific review guidelines and procedures are 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.[22] 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 2025 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 medical QHP and SADP that was certified for the 2024 plan year. Please refer to the 2018 Letter to Issuers for more information

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

regarding submission requirements pertinent to the Plan ID Crosswalk.[23]

Additionally, please refer to the 2024 Letter to Issuers for more information on two policies that CMS finalized for the 2024 plan year.[24] 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) and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual.[25]

In the 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. 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 2024 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for SADPs offered during the 2025 plan year.

Section 6. Value-based Insurance Design

The approach for 2025 remains unchanged from 2021 and later years. Please refer to the 2021 Letter to Issuers for more information.

Section 7. Alternative Payment Models (APMs)

The approach for 2025 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

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[23] *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.

[24] *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.

[25] *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.

approaches.

Section 8. Issuer Participation for the Full Plan Year

The approach for 2025 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 2025 remains in large part unchanged from the previous approaches in 2023 and 2024. Please refer to the 2023 and 2024 Letters to Issuers for a summary of these requirements.

That said, there are several minor differences between the current approach for 2025 and the previous approaches for 2024 and 2023. Specifically, for 2025, CMS finalized several minor updates to the plan designs to ensure these standardized plan options 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 2025 Payment Notice for these plan designs.

Section 10. Non-Standardized Plan Option Limits

The approach for 2025 maintains a high degree of continuity from the approach in 2024. Please refer to the preamble for 45 CFR 156.202 in the final 2024 Payment Notice and the 2024 Final Letter to Issuers for a detailed discussion of these requirements.

However, there are several differences between the approach for 2025 and the approach for 2024. Specifically, in accordance with 45 CFR 156.202(b), the number of non-standardized plan options that issuers of QHPs can offer through the FFEs and SBE-FPs will be reduced from four per product network type (as described in the definition of "product" at 45 CFR 144.103), metal level (excluding catastrophic plans), inclusion of dental and/or vision benefit coverage (as defined in § 156.202(c) of this section), and service area in the 2024 plan year, to two in the 2025 plan year and subsequent years.

Under this requirement, an issuer will, for example, be limited to offering two gold HMO and two gold PPO non-standardized plan options in the same service area in the 2025 plan year – if that issuer does not include any dental and/or vision benefit coverage benefits in those non-standardized plan options, in accordance with 45 CFR 156.202(b) and (c).

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

We also clarify that the example included in the 2024 Payment Notice that illustrated issuer flexibility to vary the inclusion of dental and/or vision benefit coverage in accordance with §

156.202(c) under the non-standardized plan option limits at § 156.202(a) through (b) failed to distinguish between the adult and pediatric dental benefit coverage categories.

In the 2024 Payment Notice (88 FR 25858), we stated that for the 2025 plan year, for example, an issuer will be permitted to offer two non-standardized gold HMOs with no additional dental or vision benefit coverage, two non-standardized gold HMOs with additional dental benefit coverage, two non-standardized gold HMOs with additional vision benefit coverage, and two non-standardized gold HMOs with additional dental and vision benefit coverage, as well as two non-standardized gold PPOs with no additional dental or vision benefit coverage, two non-standardized gold PPOs with additional dental benefit coverage, two non-standardized gold PPOs with additional vision benefit coverage, and two non-standardized gold PPOs with additional dental and vision benefit coverage, in the same service area.

However, in the 2024 plan year, issuers had the ability to vary the inclusion of dental and/or vision benefit coverage (including varying the inclusion of the distinct adult and pediatric dental benefit coverage categories) such that issuers could offer plans in the manner reflected in the following table, instead of in the more limited manner reflected in the incomplete example in the 2024 Payment Notice.

We affirm that issuers will continue to retain this flexibility for the 2025 plan year. Thus, under the non-standardized plan option limit of two for the 2025 plan year, if an issuer desires to offer the theoretical maximum number of plans, and if that issuer varies the inclusion of dental and/or vision benefit coverage in these plans in accordance with the flexibility provided for at § 156.202(c)(1) through (3), that issuer could offer a theoretical maximum of 16 plans in a given product network type, metal level, and service area in the manner demonstrated in the following table. Furthermore, if an issuer offers QHPs with two product network types (for example, HMO and PPO), that issuer could offer a theoretical maximum of 32 plans in a given metal level and service area in the manner demonstrated in the following table.

Plan	Network Type	Cost Sharing Structure	Adult Dental	Pediatric Dental	Adult Vision
1	HMO	A			
2	HMO	A	Covered		
3	HMO	A		Covered	
4	HMO	A			Covered
5	HMO	A		Covered	Covered
6	HMO	A	Covered		Covered
7	HMO	A	Covered	Covered	
8	HMO	A	Covered	Covered	Covered
9	HMO	B			
10	HMO	B	Covered		
11	HMO	B		Covered	
12	HMO	B			Covered
13	HMO	B		Covered	Covered
14	HMO	B	Covered		Covered
15	HMO	B	Covered	Covered	
16	HMO	B	Covered	Covered	Covered
17	PPO	C			

18	PPO	C	Covered		
19	PPO	C		Covered	
20	PPO	C			Covered
21	PPO	C		Covered	Covered
22	PPO	C	Covered		Covered
23	PPO	C	Covered	Covered	
24	PPO	C	Covered	Covered	Covered
25	PPO	D			
26	PPO	D	Covered		
27	PPO	D		Covered	
28	PPO	D			Covered
29	PPO	D		Covered	Covered
30	PPO	D	Covered		Covered
31	PPO	D	Covered	Covered	
32	PPO	D	Covered	Covered	Covered

We also reiterate the "service area" component of the limit on non-standardized plan options refers to Federal Information Processing Series (FIPS) code.[26] A FIPS code is a five-digit code that is unique to every county in the country. The first two digits are the State code (for example, Georgia's State code is 13), and the remaining three digits identify the county. We are defining "service area" with FIPS codes in order to provide a standardized, widely utilized, comprehensive, and mutually exclusive geographic unit for assessing consumer choice overload and adherence to non-standardized plan option limits.

In addition, in the final 2025 Payment Notice, CMS finalized an exceptions process that will allow issuers to offer additional non-standardized plan options through the FFEs and SBE-FPs exceeding the two-plan limit, if issuers demonstrate that these plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

Specifically, at § 156.202(d), 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 dental and/or vision benefit coverage, 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% 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, and service area.

Under § 156.202(d)(1), the 25% reduction in cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions will be evaluated at the level of total out-of-pocket costs for the treatment of the chronic and high-cost condition for a population of enrollees with the relevant chronic and high-cost condition. Under § 156.202(d)(2), the reduction in cost sharing must not be limited to a part of the year, or an otherwise limited scope of benefits. Under § 156.202(d)(3), the reduction in cost sharing for these benefits cannot be conditioned on a

[26] 88 FR 25858.

consumer having a particular diagnosis.

Under § 156.202(d)(4), the required reduction in cost sharing only applies to the standard variant of the plan for which an issuer seeks an exception, and not to the income-based cost-sharing reduction plan variations required by § 156.420(a), nor to the zero and limited cost sharing plan variations required by § 156.420(b). Under § 156.202(d)(5), issuers are limited to one exception per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, for each chronic and high-cost condition. Under § 156.202(d)(6), chronic and high-cost conditions that may qualify an issuer for this exception will be determined by HHS.

In the final 2025 Payment Notice,[27] we shared the following hypothetical scenario as an illustration of how we will evaluate the 25% reduction in cost sharing for benefits pertaining to the treatment of a chronic and high-cost condition. In this scenario, an issuer desires to offer two non-standardized plan options per product network type, metal level, and inclusion of dental and/or vision benefit coverage. This issuer also desires to submit an exception request for an additional non-standardized plan option that reduces cost sharing for benefits pertaining to the treatment of diabetes.

As part of the request for the additional non-standardized plan option to be excepted, the issuer chooses one of its non-standardized plan options within the limit of two for the 2025 plan year in the same product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area to serve as a point of comparison for evaluating whether the required 25% reduction in cost sharing is achieved relative to the plan the issuer is requesting to except from the non-standardized plan option limit.

The cost sharing structure in the non-standardized plan option the issuer has chosen as the in-limit comparison includes a $40 copayment exempt from the deductible for each primary care visit, an $80 copayment exempt from the deductible for each podiatrist specialist visit, an $80 copayment exempt from the deductible for each ophthalmologist specialist visit, and a 40 percent coinsurance rate exempt from the deductible for each utilization of laboratory services. The cost sharing structure in the non-standardized plan option that the issuer requests be excepted from the limit includes a $20 copayment exempt from the deductible for each primary care visit, a $70 copayment exempt from the deductible for each podiatrist visit, a $70 copayment exempt from the deductible for each ophthalmologist visit, and a 20 percent coinsurance rate exempt from the deductible for each utilization of laboratory services, with the cost sharing for all other benefits remaining the same between both plans.

Under this exceptions process, the 25% reduction in cost sharing for benefits pertaining to the treatment of a chronic and high-cost condition will not be evaluated at the individual benefit category level (in this case, primary care visit, podiatrist specialist visit, ophthalmologist specialist visit, and laboratory services) between the in-limit non-standardized plan option the issuer is using as a point of comparison and the additional non-standardized plan option the issuer is requesting to have excepted from the limit. Rather, the required reduction in cost sharing will be evaluated at the level of total out-of-pocket costs for a representative treatment scenario for the relevant chronic and high-cost condition. For the purposes of this exceptions process, a representative treatment scenario is a reasonable, annual course of treatment for a

[27] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025; Final Rule (April 2, 2024), *available at:* https://www.cms.gov/files/document/cms-9895-p-patient-protection-final.pdf.

chronic and high-cost condition that is developed by the issuer and subject to review by HHS.

In this hypothetical scenario, for example, a representative treatment scenario for the treatment of diabetes is comprised of four primary care visits, one podiatrist specialist visit, one ophthalmologist specialist visit, and the utilization of laboratory services one time.

Under the cost sharing structure in the non-standardized plan option the issuer has chosen as an in-limit point of comparison, this representative treatment scenario would result in the enrollee paying the $40 copayment exempt from the deductible for a primary care visit four times, amounting to $160; the $80 copayment exempt from the deductible for a podiatrist specialist visit one time; the $80 copayment exempt from the deductible for an ophthalmologist specialist visit one time; and, assuming a total cost of $200 for each utilization of laboratory services and a coinsurance rate of 40% exempt from the deductible for this service, one utilization of laboratory services amounting to $80. Altogether, the total out-of-pocket costs for this representative treatment scenario under the cost-sharing structure in the non-standardized plan option the issuer has chosen as an in-limit point of comparison would amount to $400.

Under the cost sharing structure in the non-standardized plan option that the issuer requests be excepted from the limit, the representative treatment scenario would result in the enrollee paying the $20 copayment exempt from the deductible for a primary care visit four times, amounting to $80; the $70 copayment exempt from the deductible for a podiatrist specialist visit one time; the $70 copayment exempt from the deductible for an ophthalmologist specialist visit one time; and, assuming a total cost of laboratory services of $200 for each utilization of laboratory services and a coinsurance rate of 20% exempt from the deductible for this service, one utilization of laboratory services amounting to $40. Altogether, the total out-of-pocket costs for this representative treatment scenario under the cost-sharing structure in the non-standardized plan option the issuer is requesting to be excepted from the limit would amount to $260.

Thus, although there is not necessarily a 25% reduction when comparing each individual benefit category between these two plans, the standard would still be satisfied, so long as the overall cost sharing (in the form of total out-of-pocket costs, which takes into consideration maximum out-of-pocket limitations and deductibles) for a population of enrollees with diabetes will still be reduced by at least 25% under the excepted non-standardized plan option (which in this case would be $260) compared to the non-standardized plan option being used as an in-limit point of comparison (which in this case would be $400). We note that an issuer seeking to utilize this exceptions process must demonstrate underlying actuarial assumptions in the required actuarial memorandum (which includes corresponding actuarial attestation) as part of the exception request.

No other plan design features (such as the inclusion of additional benefit coverage, different provider networks, different formularies, or reduced cost sharing for benefits provided through the telehealth modality) will be evaluated under this exceptions process, meaning no other differences in plan design features will allow issuers to be excepted from the limit to the number of non-standardized plan options offered per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

Additionally, in accordance with § 156.202(d)(5), issuers are limited to one exception per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, for each chronic and high-cost condition. Under this limitation, for example, if an issuer

submits exception requests for three separate plans in a given product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area (such as one plan that reduces cost sharing for benefits pertaining to the treatment of diabetes, one plan that reduces cost sharing for benefits pertaining to the treatment of plan COPD, and one plan that reduces cost sharing for benefits pertaining to the treatment of hepatitis C), we would permit exceptions for each of these plans, assuming they meet all other certification and exception requirements.

However, under this limitation, multiple exceptions will not be permitted for separate plans that reduce cost sharing for benefits pertaining to the treatment of the same chronic and high-cost condition, regardless of whether these benefits with reduced cost sharing vary between the separate plans. Thus, under this limitation, for example, if an issuer submits two exception requests for two separate plans that have reduced cost sharing for benefits pertaining to the treatment of diabetes (and both plans reduce cost sharing for insulin), only one exception would be permitted.

Similarly, if an issuer submits exception requests for two plans with reduced cost sharing for different benefits pertaining to the treatment of diabetes (with one plan reducing cost sharing for insulin, and the other reducing cost sharing for diabetic foot care, diabetic retinal exam, and diabetic lab testing), the issuer would be permitted only one exception. Given that the required reduction in cost sharing for benefits pertaining to the treatment of a chronic and high-cost condition is 25% or more, given that this reduction in cost sharing would correspondingly increase the AV of that plan, and given the AV constraints posed by the *de minimis* ranges for each metal level, we do not believe it will be feasible for issuers to reduce cost sharing for different benefits pertaining to the treatment of different chronic and high-cost conditions within the same plan.

In accordance with § 156.202(d)(6), chronic and high-cost conditions that may qualify an issuer for this exception will be determined by HHS. As described in the final 2025 Payment Notice, we noted that the four chronic and high-cost conditions included in the prescription drug adverse tiering review for the 2025 plan year (specifically, hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis) are examples of conditions that we would consider to be chronic and high-cost in nature for purposes of this standard.

However, we noted that we would also consider additional conditions to be chronic and high-cost in nature for purposes of this standard. Additional representative examples of conditions that we would consider to be chronic and high-cost in nature include but are not limited to Alzheimer's disease, kidney disease, osteoporosis, heart disease, diabetes, and all kinds of cancer. Examples of conditions that we would not consider chronic and high-cost in nature would be those that are generally acute in nature, including bronchitis, the flu, pneumonia, strep throat, and respiratory infections.

Additionally, as part of this exceptions process, at § 156.202(e), an issuer that seeks to utilize this exceptions process must submit a written justification in a form and manner and at a time prescribed by HHS that:

1. Identifies the specific chronic and high-cost condition that its additional non-standardized plan option offers substantially reduced cost sharing for, in accordance with the definition of "cost sharing" at § 156.20;

2. Identifies which benefits in the Plans and Benefits Template are discounted to provide

reduced treatment-specific cost sharing for individuals with the specified chronic and high-cost condition. These discounts must be relative to the treatment-specific cost sharing for the same corresponding benefits in the issuer's other non-standardized plan offerings in the same product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area. For the purposes of this standard, treatment specific cost sharing consists of the costs for obtaining services that pertain to the treatment of a particular chronic and high-cost condition – but not the costs for obtaining services that do not pertain to the treatment of the relevant condition. The issuer must identify all services for which the benefits substantially reduce cost sharing in the Plans and Benefits Template. These benefits must encompass a complete list of relevant services pertaining to the treatment of the relevant condition;

3. Explains how the reduced cost sharing for these services pertains to clinically indicated guidelines and a representative treatment scenario for treatment of the specified chronic and high-cost condition (and include any relevant studies, guidelines, or supplementary documents to support the application, as applicable). For the purposes of this standard, a representative treatment scenario is a reasonable, annual course of treatment for a chronic and high-cost condition that is developed by the issuer and subject to review by HHS; and

4. Includes a corresponding actuarial memorandum that explains the underlying actuarial assumptions made in the design of the plan the issuer is requesting to except. In this memorandum, an issuer must demonstrate how the benefits that are discounted to provide reduced treatment-specific cost sharing of at least 25% identified at § 156.202(e)(2) for the treatment of the condition identified at § 156.202(e)(1) under the excepted plan compare to the identified in-limit offering in the same product network type, metal level, inclusion of dental and/or vision coverage, and service area. This demonstration must specifically be in reference to the specific population that would be seeking treatment for the relevant condition and not the general population. This memorandum must also include an actuarial opinion confirming that this analysis was prepared in accordance with the appropriate Actuarial Standards of Practice and the profession's Code of Professional Conduct.

When CMS releases the QHP application templates for the 2025 plan year, CMS will provide issuers with a template justification form that they will be required to use as part of this exceptions process. Issuers seeking to utilize this exceptions process will need to submit the justification form by the initial QHP certification application submission deadline.

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.)

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 2025 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. 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 2025 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 2025 plan year. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

For the 2025 plan year, 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, eliminate duplicative requirements or reviews, and reduce stakeholder burden.

ii. Network Adequacy for QHP Issuers in FFEs

a. Time and Distance Standards

The approach for time and distance standards remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

[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.

Telehealth for Time and Distance Standards

The approach for telehealth services for time and distance standards in 2025 remains unchanged from 2023 and later years. Please refer to the 2023 Letter to Issuers for more information. As noted in the 2025 Payment Notice, we want to ensure that 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. In contrast, one can measure availability of an in-person or telehealth appointment equally.

b. Appointment Wait Times

Beginning January 1, 2025, 45 CFR 156.230(a)(2)(i)(B) requires QHP issuers, including SADP issuers, in the FFEs to meet appointment wait time standards established by the FFEs. We established those standards in Chapter 2, section 3.ii.b of the 2023 Letter to Issuers. For the 2025 plan year, QHP issuers, including SADP issuers, will be required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time. We are particularly concerned with the ability of new patients to schedule appointments with in-network providers, as more than half of enrollees on the FFEs newly enroll in QHPs or change their enrollment to a new QHP each year, and these enrollees may need to seek care as a patient new to a provider.

Provider Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

Secret Shopper Surveys

CMS will also require medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards. The third-party entity that conducts the surveys must be a separate and distinct entity from the medical QHP issuer. For example, the third-party entity and the issuer cannot be affiliated companies, and they cannot be subsidiaries of the same parent company. To limit the burden on QHP issuers, we intend to only require secret shopper surveys to be conducted for a QHP issuer's primary care (routine) and behavioral health providers. We expect to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years. This phased approach would also allow issuers to gain experience contracting with third-party entities and reporting the results via issuer compliance and monitoring activities, and it would enable CMS to ensure the effectiveness of using QHP issuer-reported secret shopper data to evaluate appointment wait times. CMS believes a phased-in approach will benefit both QHP issuers and CMS.

As SADP issuers would generally contract with specialty care (non-urgent) providers, SADP issuers would not be required to contract with a third-party entity to conduct secret shopper surveys for the 2025 plan year.

To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly

after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities. The third-party entity must conduct secret shopper surveys while presenting as a new patient (i.e., a patient attending their first-ever clinical encounter with a practitioner at the location being surveyed). CMS may require medical QHP issuers to provide CMS with documentation underlying the results of those surveys, for CMS's review. Medical QHP issuers must retain relevant documentation related to the surveys in accordance with the broad record retention policies set forth at 45 CFR 156.705.

A QHP issuer's third-party entity would be required to administer secret shopper surveys to a survey pool, provided to issuers by CMS, that includes a statistically valid representation of providers across the QHP's network that are accessible to consumers within the requisite time and distance standards in the service area. The third-party entity shall identify a statistically valid, minimum sample size for each provider type.

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 (i.e., by reporting results that do not reflect that enrollees seeking an appointment are able to schedule an appointment within the time frames above at least 90% of the time) based on only those providers that count toward the issuer's satisfaction of the time and distance requirements under § 156.230(a)(2)(i)(A) would need to add more contracted providers to the network to come into alignment with the standards.

We intend to release additional technical guidance to further describe secret shopper survey implementation requirements in advance of the 2025 plan year so that issuers have sufficient time to review that guidance as they contract with third-party entities.

Telehealth for Appointment Wait Time Standards

In order to assess compliance with the appointment wait time standard, the third-party entities should collect information from provider offices on the availability of both in-person and telehealth appointments. We received several comments in response to the Draft Letter to Issuers about how consumers are using telehealth, especially in the context of mental health services. The comments explained that by not counting telehealth, we would be undercounting access to primary care and behavioral health. While the approach for telehealth services for time and distance standards in 2025 remains unchanged from 2023 and later years, the appointment wait time policy for the 2025 plan year will take telehealth into account as follows. The calculation ofthe 90% compliance rate for secret shopper surveys of appointment wait times will be based on whichever appointment, in-person or telehealth, has the shortest wait time. We acknowledge that telehealth is an important option for some patients to access care and the data collected in this first year of reporting for appointment wait times will be used to inform decisions regarding how we will measure compliance in future years.

Primary Care and Behavioral Health Provider Taxonomy

We define primary care (routine) and behavioral health care providers for the purpose of assessing appointment wait times standards to include providers with the taxonomy codes listed in tables 2.1 and 2.2 below, which contain taxonomy codes that correspond to each provider type as listed in the Network Adequacy template.

Table 2.1 Primary Care Provider Types for Primary Care (Routine) Category for Appointment Wait Time Standards

National Uniform Claim Committee (NUCC) Taxonomy Code	Provider Type Descriptions	NUCC Display Name
207Q00000X	Family Medicine	Family Medicine Physician
207QA0000X	Family Medicine	Adolescent Medicine (Family Medicine) Physician
207QA0505X	Family Medicine	Adult Medicine Physician
207QB0002X	Family Medicine	Obesity Medicine (Family Medicine) Physician
208D00000X	General Practice	General Practice Physician
207QG0300X	Geriatrics	Geriatric Medicine (Family Medicine) Physician
207RG0300X	Geriatrics	Geriatric Medicine (Internal Medicine) Physician
207R00000X	Internal Medicine	Internal Medicine Physician
207RA0000X	Internal Medicine	Adolescent Medicine (Internal Medicine) Physician
207RB0002X	Internal Medicine	Obesity Medicine (Internal Medicine) Physician
363LA2200X	Primary Care - Advanced Registered Nurse Practitioner	Adult Health Nurse Practitioner
363LF0000X	Primary Care - Advanced Registered Nurse Practitioner	Family Nurse Practitioner
363LP2300X	Primary Care - Advanced Registered Nurse Practitioner	Primary Care Nurse Practitioner
363A00000X	Primary Care - Physician Assistant	Physician Assistant
363AM0700X	Primary Care - Physician Assistant	Medical Physician Assistant
208000000X	Primary Care - Pediatric	Pediatrics Physician
2080A0000X	Primary Care - Pediatric	Pediatric Adolescent Medicine Physician

Table 2.2 Behavioral Health Provider Types for Behavioral Health Category for Appointment Wait Time Standards

NUCC Taxonomy Code	Provider Type Description	NUCC Display Name
101YA0400X	Addiction (Substance Use Disorder) Counselor	Addiction (Substance Use Disorder) Counselor
207LA0401X	Addiction Medicine Physician	Addiction Medicine

		(Anesthesiology) Physician
207QA0401X	Addiction Medicine Physician	Addiction Medicine (Family Medicine) Physician
207RA0401X	Addiction Medicine Physician	Addiction Medicine (Internal Medicine) Physician
2083A0300X	Addiction Medicine Physician	Addiction Medicine (Preventive Medicine) Physician
103K00000X	Behavioral Analyst	Behavioral Analyst
363LP0808X	Behavioral Health - Advanced Practice Registered Nurse	Psychiatric/Mental Health Nurse Practitioner
364SP0808X	Behavioral Health - Advanced Practice Registered Nurse	Psychiatric/Mental Health Clinical Nurse Specialist
101Y00000X	Counselor (Mental Health and Professional)	Counselor
101YM0800X	Counselor (Mental Health and Professional)	Mental Health Counselor
101YP2500X	Counselor (Mental Health and Professional)	Professional Counselor
106H00000X	Marriage and Family Therapist	Marriage & Family Therapist
103T00000X	Psychologist	Psychologist
103TA0400X	Psychologist	Addiction (Substance Use Disorder) Psychologist
103TA0700X	Psychologist	Adult Development & Aging Psychologist
103TB0200X	Psychologist	Cognitive & Behavioral Psychologist
103TC0700X	Psychologist	Clinical Psychologist
103TC1900X	Psychologist	Counseling Psychologist
103TC2200X	Psychologist	Clinical Child & Adolescent Psychologist
103TE1100X	Psychologist	Exercise & Sports Psychologist
103TF0000X	Psychologist	Family Psychologist
103TF0200X	Psychologist	Forensic Psychologist
103TH0004X	Psychologist	Health Psychologist
103TH0100X	Psychologist	Health Service Psychologist
103TM1800X	Psychologist	Intellectual & Developmental Disabilities Psychologist
103TP0016X	Psychologist	Prescribing (Medical) Psychologist
103TP0814X	Psychologist	Psychoanalysis Psychologist
103TP2701X	Psychologist	Group Psychotherapy Psychologist
103TR0400X	Psychologist	Rehabilitation Psychologist
103TS0200X	Psychologist	School Psychologist
104100000X	Social Worker	Social Worker
1041C0700X	Social Worker	Clinical Social Worker
1041S0200X	Social Worker	School Social Worker

iv. Network Adequacy Justification Process

For the 2025 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, we will not consider these justifications as to an issuer's failure to contract with a third party to administer the secret shopper provider surveys. The justification process remains unchanged from the 2024 plan year. CMS will only accept the official Network Adequacy Justification Form, which is a partially prepopulated Excel document. CMS will review any updated provider data submitted on the issuer's 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.

For rural counties and counties with extreme access considerations (CEAC) for which issuers report within the issuer's Network Adequacy Justification Form a provider supply shortage of primary care pediatricians, CMS will allow the family medicine physician provider type to count toward satisfaction of the "Primary Care – Pediatric" specialty type. This is in addition to the family medicine physician provider type currently counting toward issuer satisfaction of the "Primary Care – Adult" specialty type.

v. Network Transparency

The approach for network transparency for 2025 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 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[29] provided to issuers and updated annually) within the plan's service area in the issuer's provider network(s). The ECP standard for the 2025 plan year and the approach for reviews of the ECP standard remain the same as for the 2024 plan year. Please refer to the 2018-2024 Letters to Issuers for full details.

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 will continue to assess these standards and any related burden for issuers 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 2024[30] for more detailed information on issuer data collection and reporting requirements for the 2024 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 2025 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 BHPs.

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[29] *See* HHS ECP List, *available at:* https://www.qhpcertification.cms.gov/s/FinalPY2024ECPListPublicVersion_072523.xlsx?v=1.

[30] *See* Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024 (September 2023), *available at:* https://www.cms.gov/files/document/qrs-and-qhp-enrollee-survey-technical-guidance-2024.pdf.

Section 9. Review of Rates and Forms

The approach for reviewing rate filings for the 2025 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.[31]

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 submitted in SERFF.[32] This functionality does not apply to States that do not have an Effective Rate Review Program[33] 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's 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.[34] 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.[35] 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.[36]

Section 10. Discriminatory Benefit Design

The approach to discriminatory benefit design generally remains unchanged from 2017 and later years. Please refer to the 2017 Letter to Issuers for more information regarding discriminatory benefit design and QHP discriminatory benefit design. The HHS Notice of Benefit and Payment Parameters for 2023 Final Rule (final 2023 Payment Notice)[37] refined the essential health benefits (EHB) nondiscrimination policy for health plan designs. CMS will assess compliance of

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[31] *See, e.g.,* the Unified Rate Review Instructions, *available at*: https://www.cms.gov/files/document/urr-py23-instructions.pdf.

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

[33] See *supra* note 17.

[34] See *supra* note 18.

[35] See *supra* note 20.

[36] 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."

[37] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023; Final Rule (May 6, 2022), 87 CFR 27208, *available at:* https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.

QHPs in the FFEs by ensuring consistent application of EHB nondiscrimination policy, which will better safeguard consumers who depend on nondiscrimination protections. While States are generally the primary enforcers of EHB policy, CMS will continue to monitor issuer compliance with EHB nondiscrimination policy and provide technical assistance and available data, research, or other information to States. CMS will assess benefit designs to ensure they are nondiscriminatory and consistent with 45 CFR 156.125, regardless of how a discriminatory benefit design originated.

Section 11. Prescription Drugs

CMS will continue conducting an adverse tiering review as one of the prescription drug reviews.[38] 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 2025 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 2025 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 misleading.[39] More information about this review is available in the 2024 Letter to Issuers, and

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

[39] In practice, CMS and stakeholders often use the term "plan variants" to refer to "plan variations." Per 45 CFR

in the Plan Marketing Name Fact Sheet.[40]

Section 16. Interoperability

For the 2025 plan year, the policy remains unchanged from the 2022 plan year, and more information on this review can be found in the 2024 Letter to Issuers.[41]

CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION

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

Section 1. Consumer Support Tools

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

Section 2. Transparency in Coverage Reporting

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

Pursuant to 45 CFR 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection request, CMS-10572, "Transparency in Coverage Reporting by Qualified Health Plan Issuers," under the Paperwork Reduction Act (PRA) to OMB for an additional 3-year collection period. This updated information collection request (OMB Control Number 0938-1310) was approved on April 12, 2022, and covers data collected for the 2025 plan year. The data elements issuers must report for the 2025 plan year are unchanged from those collected as part of QHP certification for the 2024 plan year. Issuers must provide both their Transparency in Coverage data and their Transparency in Coverage URL submissions via the MPMS module in HIOS. CMS is also exploring other ways to enhance the accuracy of these data, including whether to use these data for compliance purposes beginning with the 2025 plan year.

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).

[40] *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. Also *see* Plan Marketing Name Fact Sheet, *available at*: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits (scroll to "Plan Marketing Name Fact Sheet").

[41] *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. Also, note that in February 2024, CMS published the Advancing Interoperability and Improving Prior Authorization Processes Final Rule, *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 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: 2025 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 2024. Please refer to the 2018 through 2024 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For the 2025 plan year, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 22.964 percentage point increase in the Consumer Price Index (CPI) for dental services of 563.582 for 2023 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $80.37 to a total of $430.37. 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 2025 plan year will be $425 for one child and $850 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 2025 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 issuers to monitor the activities of agents and brokers participating in the FFEs and SBE-FPs, and prevent fraud, waste, and abuse.

CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

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

Section 1. Coverage Appeals

The approach to coverage appeals generally remains unchanged from 2018 and later years. However, please note that 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.[42] 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.[43]

That guidance is described in more detail in *Chapter 6, Section 3: Meaningful Access*.

Section 2. Consumer Case Tracking

The approach to consumer case tracking remains unchanged from 2018 and later years. Please

[42] County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) (November 2023), *available at*: https://www.cms.gov/files/document/clas-county-data-2023.pdf.
[43] 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.

refer to the 2018 Letter to Issuers for more information.

Section 3. Meaningful Access

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

The approach to meaningful access generally remains unchanged from 2023. However, please note that 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 and in the summary of benefits and coverage (SBC) and uniform glossary rules implementing section 2715 of the PHS Act.[44] These provisions require group health plans and issuers offering group and individual health insurance coverage to provide SBC, internal claims and appeals, and external review notices in a culturally and linguistically appropriate manner. Pursuant to 45 CFR 147.136(e) and 45 CFR 147.200(a)(5), this means providing oral language services, translated notices, and taglines, with respect to an address in any U.S. county to which a notice is sent, in a particular non-English language if 10% or more of the population residing in the county is literate only in that same non-English language. In the updated guidance, the Departments indicate the languages and counties that meet this threshold. 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.[45]

Section 4. Summary of Benefits and Coverage (SBC)

The guidance on the SBC generally remains unchanged from 2023. However, please note that 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 SBC and uniform glossary rules implementing section 2715 of the PHS Act.[46] 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.[47]

That guidance is described in more detail in the previous section, *Chapter 6, Section 3: Meaningful Access*.

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

[44] See *supra* note 42.
[45] See *supra* note 43.
[46] See *supra* note 42.
[47] See *supra* note 43.

years. For more information, please refer to the 2018 Letter to Issuers.[48]

[48] 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.