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: Samara Lorenz, Director, Oversight Group

To: Health Insurance Issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming

Subject: Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2025

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is responsible for enforcing provisions of title XXVII of the Public Health Service Act (PHS Act), as amended or extended by the Patient Protection and Affordable Care Act (ACA) and the Consolidated Appropriations Act, 2021 (CAA), among other laws, with respect to health insurance issuers in the individual and group markets when a state or territory informs CMS that it does not have authority to enforce or is not otherwise enforcing one or more of the applicable provisions of that title, or when CMS determines that a state or territory is not substantially enforcing one or more of the applicable provisions of that title.

The states and territories listed above have informed CMS that they are not enforcing certain provisions of the PHS Act, as added or amended by the ACA and the CAA.[1] In situations where CMS is responsible for enforcement, one of the ways CMS enforces these provisions is through the review of policy forms for compliance prior to sale. Within CMS, the Oversight Group in the Center for Consumer Information & Insurance Oversight (CCIIO) is primarily tasked with these duties.

II. Difference Between a Product and a Plan

All form filing submissions to CMS must be made at the "product" level. This means that there may be more than one filing per issuer per market. The terms "product" and "plan" are defined in regulations at 45 CFR 144.103. A product is a discrete package of health insurance coverage benefits that are offered using a particular product network type (e.g., HMO, PPO, EPO, POS or indemnity) within a service area.

A plan is the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. Plans within a product may vary with respect to

[1] See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA for letters from CCIIO to states that are not enforcing provisions of the CAA.

cost-sharing structure, provider network, and service area.[2] Plans within a product may not vary with respect to which benefits are offered, meaning the product's covered items and services must be consistent, including any visit or other frequency limits on the same covered benefits.

III. Form Filing Instructions

- Issuers must submit forms to the CMS Instance in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rates and Forms Filing (SERFF) at https://login.serff.com/serff/
- Issuers must submit forms for each product in a separate submission in SERFF, which must include all plans to be offered for that product.[3]
- If you are submitting more than one filing for a single product network type (e.g., PPO, POS, EPO and HMO), provide a high-level explanation of the benefit differences between the filings.
- Issuers are required to submit products that contain a plan or plans that will be submitted for certification as a qualified health plan (QHP) to be offered through the Federally-Facilitated Exchange or a State-Based Exchange.
- Issuers are not required to resubmit a product that contains only non-QHPs if the product was previously reviewed and acknowledged by CMS Form Filing in a prior filing year, unless there is a material change to any plan within the product.
    - A material change is any change to the coverage offered that independently or in conjunction with other contemporaneous changes would be considered by the typical enrollee to be an important change, including changes that enhance or reduce benefits, increase premiums or cost-sharing, or impose new referral requirements.
- Issuers must submit a full and complete filing for each product. It is not sufficient to submit updated versions of only some required documents or portions of documents. Insert pages and matrix filings are not acceptable.
- QHPs generally must be available off-Exchange, but issuers are not required to submit a separate form filing for the off-Exchange offering of the same plan.
- Issuers are not required to submit forms for excepted benefits, account-based plans and short-term, limited-duration insurance.[4]
- In the **Filing Description Section** under the **General Information Tab**:
    - Enter the associated Health Insurance and Oversight System (HIOS) number and Product ID. Issuers offering products in the territories do not need HIOS Issuer or Product IDs.
    - If applicable, enter the coverage level for each plan within the product (i.e., bronze, silver, gold, platinum, or catastrophic).
- Under the **State Specific Tab**:
    - State whether the product will be offered in the individual, small group, large group, or student health market.
    - State whether the product is grandmothered,[5] grandfathered, or neither.
    - If the product will be offered in the small group or large group market, provide the group

[2] The combination of the service areas for all plans offered within a product constitutes the total service area of the product.
[3] A single product submission may include qualified health plans (QHPs) and non-QHPs.
[4] Excepted benefits are defined at 45 CFR 146.145 and 148.220. Also see 45 CFR 149.20(b). Short-term, limited duration insurance in defined at 45 CFR 144.103. Also see 45 CFR 149.20(b).
[5] "Grandmothered" or "transitional" plans refers to coverage that has been renewed under CMS's non-enforcement policy continually since 2014. See https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

market type (Employer, Association, Blanket, Discretionary, Trust, Non Employer Group, or Other). If "Other," specify the market type.
    - State whether the product includes a plan(s) that will be submitted for certification as a QHP (regardless of whether the plan will be offered on the Federally-Facilitated Exchange or a State-Based Exchange).
- Under the **Companies and Contact Tab**, provide company contacts who can timely respond to inquiries and objection letters regarding the filing, and ensure such contact information is complete, correct, and current.
- Submit all forms and plan documents in the **Form Schedule Tab** or **Supporting Documentation Tab**, as applicable. Do not use the **Note to Reviewer** function to submit forms or plan documents.
- Only file ONE form or plan document per line item.
- Forms must be submitted in SERFF in final form. Plan documents must be submitted as they will be offered to enrollees. A drafted document or a redlined marked up document submitted under the **Form Schedule Tab**, will not be accepted. Redline documents are used only to reference changes from previous versions submitted during the current filing season and must be submitted in the **Supporting Documentation Tab**. The associated clean version of the revised document must be submitted under the **Form Schedule Tab**.
- Microsoft Word documents cannot be uploaded to SERFF. All text files must be in Adobe Acrobat PDF format. Spreadsheets must be attached in Excel format. BMP, PNG, and JPG are acceptable formats for screenshots. File names cannot include a comma(s).
- The maximum file size limit for uploads to SERFF is 5MB.
- Scanned documents must be converted to a readable format using the optical character recognition (OCR) feature in Adobe Acrobat prior to uploading in SERFF.
- Do not submit locked or password protected PDFs. The locking of documents slows down the review process.
- The information submitted in SERFF must be the same information submitted to CMS Plan Management in HIOS. If the information is different, use the **Note to Reviewer** function in SERFF to request that CMS Form Filing reopen the filing. Once the filing is reopened, upload in SERFF the new documents that correspond to the documents submitted to HIOS.
- If you require an extension, use the **Note to Reviewer** function in SERFF to submit a request stating the reason you need the extension and the requested extension length (1 to 3 business days), at least 24 hours prior to the given deadline. Requests will be considered on a case-by-case basis. You will be notified that the request has been approved or denied, and the length of the extension, via a **Note to Filer** under the **Filing Correspondence Tab** in SERFF. CMS will not grant an extension beyond 3 business days.
- If you need to withdraw a plan, notify CMS immediately via the **Note to Reviewer** function in SERFF, stating your intention to withdraw. If the filing is still open, CMS will send its disposition that the filing has been withdrawn. If the filing is closed, CMS will reopen the filing and then send the withdrawn disposition.

For additional information about SERFF, including participation details and how to sign up, call (816) 783-8990 or email serffhelp@naic.org.

IV. CAA Submission Instructions

The CAA imposed requirements related to surprise medical bills and transparency in health care for

health insurance issuers, generally for plan years beginning on or after January 1, 2022.[6] In order to ensure compliance with certain provisions of the CAA, CMS is requiring health insurance issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming to submit form filings for all health insurance products in the individual and group markets, including fully insured small group and large group market plans, student health insurance coverage, grandfathered plans, and transitional ("grandmothered") plans, to the CMS instance in SERFF at https://login.serff.com/serff/.

CMS will be reviewing form filings for compliance with the following provisions of the Public Health Service Act (PHS Act), as added by the CAA, in states where CMS directly enforces such provisions:

- PHS Act section 2799A-1(a)(1) and (a)(3) – Preventing Surprise Medical Bills – Emergency services;
- PHS Act section 2799A-1(b) – Preventing Surprise Medical Bills – Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities;
- PHS Act section 2799A-1(e) – Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations;
- PHS Act section 2799A-2(a) – Ending Surprise Air Ambulance Bills; and
- PHS Act section 2799A-3 – Continuity of Care.

Table 1, below, lists the forms that issuers in the specified states and territories must submit in SERFF and indicates the appropriate tab for each form.

Table 1 – Required Forms and Documents for All Form Filing Submissions in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming

Form Schedule Tab
Group master policy[7]
Evidence of coverage or individual policy
Riders, endorsements, and amendments[8]
Schedule of benefits for each plan and CSR plan variation
Supporting Documentation Tab

[6] For more information see FAQS about ACA and CAA, 2021 Implementation Part 49 (August 20, 2021) at: https://www.hhs.gov/guidance/document/faqs-about-affordable-care-act-and-consolidated-appropriations-act-2021-implementation.

[7] For group market product submissions only.

[8] Optional benefit riders are not permitted for plans that are subject to the single risk pool requirements.

Explanation of variability
Sample plan or insurance identification (ID) card
Grandfathered plans excel spreadsheet
Grandfathered plans attestation

For issuers in CAA Enforcement states and territories:

- Under the **Form Schedule Tab** in SERFF:
    - Upload the following documents, as applicable: Group Master Policy (for group market product submissions only); Evidence of Coverage or Individual Policy; riders, endorsements, and amendments; and the Schedule of Benefits for each plan and CSR plan variation.
    - Do not file optional benefit riders for plans that are subject to the single risk pool requirement.
- Under the **Supporting Documentation Tab** in SERFF**:**
    - Upload the following documents, as applicable: Explanation of Variability, Sample Plan or Insurance Identification (ID) Card, Grandfathered Plans Excel Spreadsheet, Grandfathered Plans Attestation.
        - Issuers may submit forms with bracketed text for all applicable benefit design options and cost sharing ranges to account for variability of student health and large group market product options. Issuers that submit forms with such text bracketed must also provide an accompanying Explanation of Variability. The Explanation of Variability should include the relevant page number, section number and header (as applicable), bracketed text, and an explanation of when specific text or cost sharing applies.
    - Upload a sample plan or insurance ID card. If you submitted a sample Summary of Benefits and Coverage as instructed by *Section V* of these instructions for ACA form filing submissions, the sample ID card must correspond to the submitted Summary of Benefits and Coverage.
        - Use the Comment function to enter the title of the document that contains the Schedule of Benefits and Coverage for the plan that corresponds to the sample ID card.
        - Use the Comment function to input the form schedule line item for the plan document that contains the Statement of Benefits for the plan that corresponds to the sample ID card.
    - Upload a Grandfathered Plans Excel Spreadsheet and Grandfathered Plans Attestation as directed in S*ection VI Grandfathered Plans* of these instructions, if applicable.

V. ACA Enforcement

In addition to reviewing form filings for CAA compliance, CMS will also review form filings in Missouri, Oklahoma, Tennessee, Texas, and Wyoming for compliance with applicable ACA requirements that CMS is responsible for enforcing. Issuers in these five states must submit documents for all non-

grandfathered health insurance products in the individual[9] and group markets, to the CMS instance in SERFF at https://login.serff.com/serff/.

In addition to the required forms in Table 1, issuers in Missouri, Oklahoma, Tennessee, Texas and Wyoming must submit in SERFF the documents in Table 2 for all non-grandfathered products in the individual and group markets.[10]

As stated in the 2025 Final Letter to Issuers in the Federally-facilitated Exchanges, there are additional documents specific to QHP certification that CMS requires issuers submit.[11] For QHPs, completed templates and justifications must be uploaded into the HIOS Plan Management and Market Wide Functions Module[12] and should not be submitted through the SERFF **Supporting Documentation Tab**. Please refer to the 2025 Final Letter to Issuers in the Federally-facilitated Exchanges for complete and final instructions for submitting QHP templates and justifications. Additionally, issuers in all states must submit rate filing information to CMS.[13] For more information on the submission of rate information, please email ratereview@cms.hhs.gov.

Table 2 – Additional Required Documents for Form Filing Submissions for Non-Grandfathered Products in Missouri, Oklahoma, Tennessee, Texas, and Wyoming

Form Schedule Tab
Notice of appeals and external review rights
Supporting Documentation Tab
Summary of Benefits and Coverage (SBC)[14]
Plans & Benefits Template, in .xlsx format, for non-QHPs only
CMS Prescription Drug Template (one per product in Excel format) for non-QHPs only, except large group market
Results of the Actuarial Value Calculator (screen shot or in Excel format) for non-QHPs only

[9] Student health insurance plans are defined as individual market plans, and are generally subject to the individual market requirements under title XXVII of the PHS Act.
[10] The additional documents listed in Table 2 are not required for grandmothered products.
[11] The 2025 Final Letter to Issuers in the Federally-facilitated Exchanges is available at: https://www.cms.gov/files/document/2025-letter-issuers.pdf.
[12] Templates are available at: https://www.qhpcertification.cms.gov/s/QHP.
[13] 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, available at: https://www.cms.gov/files/document/2024-final-rate-review-bulletin.pdf.
[14] One SBC is required per network type. For a product submission that includes plans designed to comply with metal level actuarial value requirements, issuers should submit an SBC for a silver level plan. Additionally, one American Indian/Alaska Native zero cost share and one American Indian/Alaska Native limited cost share SBC should be included if applicable.

Unique Plan Design Supporting Documentation and Justification for non-QHPs only
Essential Health Benefit (EHB) Substituted Benefit (Actuarial Equivalent) Justification for non-QHPs only
Formulary—Inadequate Category/Class Count Supporting Documentation and Justification for non-QHPs only

For issuers submitting non-grandfathered coverage only submissions in ACA Enforcement states:

- In the **Filing Description Section** under the **General Information Tab:**
    - Identify the name of and line item for the plan documents that correspond to the AI/AN no cost sharing option SBC and the limited cost sharing option SBC.
    - Include the activation date of SBC weblinks for non-QHPs only. Weblink activation dates must be prior to open enrollment.
    - Issuers that utilize a single document, such as the Plans & Benefits Template or the CMS Prescription Drug Template, for multiple products must include the corresponding SERFF tracking numbers for the other products listed. For example, if an issuer lists products A, B, and C on the Plans & Benefits Template, the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products B and C in the **Filing Description Section** under the **General Information Tab** for the product A filing. Additionally, the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products A and C in the **Filing Description Section** under the **General Information Tab** for the product B filing, and the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products A and B in the **Filing Description Section** under the **General Information Tab** for the product C filing.
- Under the **Form Schedule Tab** in SERFF, upload the Notice of Appeals and External Review Rights.
- Under the **Supporting Documentation Tab** in SERFF**:**
    - Upload the following documents for non-QHPs only: Plans & Benefits Template, in .xlsx format; CMS Prescription Drug Template (one per product in Excel format), except for large group market; Results of the Actuarial Value Calculator (screenshot or in Excel format); Unique Plan Design Supporting Documentation and Justification; Essential Health Benefit (EHB) Substituted Benefit (Actuarial Equivalent) Justification; Formulary—Inadequate Category/Class Count Supporting Documentation and Justification.
        - Run your CMS Prescription Drug Template through the plan year 2025 RX Tool to ensure that there are no CMS Prescription Drug Template errors and to provide CMS with the Combined Prescription Drug Supporting Documentation and Justification for any deficiencies identified as part of this process. This will reduce the number of Prescription Drug Template review issues.
    - Upload one SBC for a QHP offered to individuals who are recognized as American Indian or Alaska Native (AI/ANs) for the no cost sharing option and one SBC for the limited cost sharing option.
    - In addition, submit one SBC for each product network type for one of your plans. We encourage issuers to provide a silver-level plan SBC if possible.

VI. Grandfathered Plans

CMS is permitting issuers with more than 30 grandfathered plans in a market(s) (individual, small group, and/or large group) to submit form filings for only 20 percent of the grandfathered plans in that market(s) to CMS for review for compliance with the CAA. Issuers that use this accommodation to submit only 20 percent of the grandfathered plans for each respective market in which they have more than 30 grandfathered plans, must submit the plans with the highest enrollment, in the manner prescribed in these instructions. The plan filings that an issuer submits as part of its 20 percent sample of plans for plan year 2025 cannot be the same as the plans that were submitted as part of the 10 percent sample for plan year 2024. Notwithstanding this accommodation, if an issuer has made a material change that would not otherwise cause a loss of grandfather status to any of its grandfathered plans that were submitted to CMS for plan year 2024, it must resubmit form filings for those plans with material changes for CMS review for plan year 2025. These filings will not count towards the 20 percent sample requirement for plans that are using the accommodation but will be in addition to the plan filings that are included in the 20 percent sample for plan year 2025.

If 20 percent of an issuer's grandfathered plans, for each market type, does not equal a whole number, the issuer must round up and submit the next whole number of plans. For example, for an issuer that has 112 grandfathered plans in the individual market, 20 percent of 112 is 22.4, which is not a whole number. In this case, the issuer would round up and submit the 23 grandfathered plans with the highest enrollment in the individual market.

Issuers are responsible for ensuring all grandfathered plans are in compliance with the applicable CAA requirements, implementing regulations, and guidance. To verify CAA compliance, at any time, CMS may request and review the form filings for the grandfathered plans that issuers did not previously submit for review.

An issuer with 30 or fewer grandfathered plans, per market type, must submit form filings for all of its grandfathered plans, for each market, for CMS's review for compliance with CAA requirements.

A. Grandfathered Plans Excel Spreadsheet

All issuers of grandfathered plans must submit an Excel spreadsheet listing all of the issuer's grandfathered plans, including those submitted to CMS in a prior filing year, those submitted this filing year, and those submitted not submitted to CMS for review, in addition to the documentation required in these instructions. The spreadsheet must have eight columns that indicate for each grandfathered plan the plan name; market type; number of enrollees; the earliest date on which the 2025 plan or policy year will start; whether the plan's form filings have been or are being submitted to CMS for review; the plan year(s) for which the plan has been submitted to CMS, if applicable; whether there was a material change from the plan year 2024 submission, if applicable; and the SERFF filing number for grandfathered plans that are now being submitted for review for plan year 2025. The plans should be listed in descending order based on the number of enrollees. The spreadsheet must also indicate whether the issuer is electing to submit only 20 percent of its grandfathered plans for CMS review.

For example:

Issuer X elects to submit only 20 percent of its grandfathered plans for CMS review.							
Plan Name	**Market Type**	**Number of Enrollees**	**Earliest 2025 Plan or Policy**	**Submitted to CMS**	**Plan Year of**	**Material Change from Plan**	**SERFF Tracking Number**

		Per Market Type	Year Start Date		Submission to CMS	Year 2024 Submission	
Plan A	Small Group	134	06/01/2025	Yes	2024	No	N/A
Plan B	Small Group	48	03/15/2025	Yes	2024 and 2025	Yes	X1234567
Plan C	Individual	17	02/01/2025	Yes	2025	N/A	X7654321
Plan D	Small Group	27	03/01/2025	No	N/A	N/A	N/A

The spreadsheet should be saved under the following naming convention: IssuerName_State_GrandfatheredPlans.xlsx. The spreadsheet must be uploaded once under the **Supporting Documentation Tab** within the SERFF filing for the plan with the highest enrollment.

B. Grandfathered Plans Attestation

CMS is collecting an attestation from issuers with more than 30 grandfathered plans that elect to use this accommodation. Such issuers must attest that:

1. The Excel spreadsheet listing all the issuer's grandfathered plans is complete and accurate;
2. All grandfathered plans listed in the Excel spreadsheet are in compliance or will be brought into compliance with the CAA requirements, implementing regulations, and guidance after CMS's review of the submitted grandfathered plans is complete and;
3. The issuer will ensure all necessary conforming revisions are made to the non-submitted grandfathered plans based on CMS's review of and feedback on the submitted plans before the start of the 2025 plan or policy year.

An issuer may authorize any appropriate individual within the organization, such as the compliance officer, to attest on its behalf.

The attestation should be saved in Adobe Acrobat PDF format and under the following naming convention: IssuerName_State_Attestation_CAA_Compliance.pdf. The attestation must be uploaded once under the **Supporting Documentation Tab** within the SERFF filing for the plan with the highest enrollment.

VII. Deadlines

May 15, 2024, is the deadline for filing forms for all products subject to ACA and/or CAA compliance review, with the exception of forms for student health insurance products and products offered in the large group market, which are both due 60 days prior to the coverage effective or renewal date. Issuers must submit to CMS forms for student health insurance products with a policy year that begins in 2025 (e.g., the 2025-2026 school year). CMS reminds issuers subject to the *Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2024*[15] to submit forms for student health insurance products with a policy year that begins in 2024 (e.g., the 2024 – 2025 school

[15] See Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2024 available at: https://www.cms.gov/files/document/py2024-form-filing-instructions.pdf.

year).

All communication regarding form filing submissions will be conducted through the SERFF **Filing Correspondence Tab**. Issuers should frequently monitor the **Filing Correspondence Tab** for Objection Letters and Notes to Filers, to ensure that they are responding to any and all CMS communications or requests within the given deadlines.

Please note that failure to comply with deadlines may result in submitted forms not being reviewed on time and potential QHP plan suppression during Open Enrollment.[16] If an issuer sells a plan without submitting forms for review, or prior to the completion of form review, the issuer may be referred to the appropriate state or CMS market conduct team for further investigation.[17]

VIII. Qualified Health Plans

Prior to the QHP Application finalization deadline, issuers may make changes to their PY 2025 QHP Application data without state or CMS authorization. After the submission finalization deadline,[18] issuers may not add new plans to a QHP Application. CMS may allow issuers to make critical data corrections in order to correct data display errors on HealthCare.gov and align QHP data display with products and plans approved by the state. CMS will not allow substantive data changes that would alter the QHPs approved by CMS that will require re-review for QHP certification. QHP Issuers in Missouri, Oklahoma, Tennessee, Texas and Wyoming that wish to make data change requests after the finalization deadline must submit a State Authorization of QHP Data Change Request form to CMS Form Filing team for authorization before completing a data change request in the Plan Management Community.[19] CMS will not be reviewing Data Change Requests in states where it is only reviewing form filings for CAA compliance.

Failure to properly identify and make any necessary QHP application revisions may result in suppression, decertification, or a QHP compliance review.

IX. Coordination with State Reviewers

Open/Pending Filings

If a filing is open or pending review with CMS, and an issuer needs to revise a document in response to a state objection or a change in state law, the issuer must use the Amendment Filing Function within SERFF to upload the clean and redlined versions of the revised document. Issuers can find the Amendment Filing Function under the **Filing Correspondence Tab**. Issuers should refer to the SERFF Industry Manual, PDF pgs. 175 – 182, for step-by-step instructions.

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[16] See 45 CFR 156.815(b).
[17] See 45 CFR 150.313(b).
[18] See Final Key Dates for Calendar Year 2024: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; Form Review; and Risk Adjustment available at: https://www.cms.gov/files/document/final-cy24-key-dates-tables.pdf.
[19] Additional information and instructions on QHP Data Change Request is available at: https://www.qhpcertification.cms.gov/s/Data%20Change%20Windows.

The issuer must provide the following information in the comment field of the Amendment Filing Function when they upload the revised document(s):
(a) A description of the changes made, including the corresponding document names, impacted sections, and their respective page numbers;
(b) Reason for the changes (e.g., state regulatory authority objection, or change in state law);
(c) If applicable, contact information of the State Reviewer who required the change(s) described under (a);
(d) Citation of the applicable state law that supports the changes described under (a); and
(e) A note as to whether the change affects other documents filed with CMS, such as rate filings or templates for QHP certification, and whether the applicable sections of CMS have been notified of the change.

If applicable, the issuer must also upload, in Adobe Acrobat Reader PDF format, a copy of the objection letter from the State Reviewer who required the change(s).

CMS will issue an Objection Letter and work directly with the State Reviewer and the issuer if any compliance issues are identified.

Acknowledged/Closed Filings

If an issuer received a Disposition from CMS for an acknowledged or closed filing, and the issuer needs to revise a document in response to a state objection or a change in state law, the issuer must send CMS a request to reopen the filing, via SERFF, using the Note to Reviewer function, under the **Filing Correspondence Tab**.

When an issuer submits such a request, the issuer should include the reason for the changes (e.g., state regulatory authority objection, or a change in state law).

CMS will review the issuer's request to reopen the filing, and will notify the issuer, via SERFF, using the Note to Filer Function, when the filing has been reopened.

The issuer will need to follow the same steps described above for open/pending filings and use the Amendment Filing Function to upload the clean and redlined revised document and, if applicable a copy of the state Objection Letter, as well as use the comment field within the Amendment Filing Function, to provide the same information listed in (a) through (e).

At the conclusion of CMS's review of the revised document, CMS will notify the issuer of its determination by issuing, via SERFF, either an Objection Letter or a Disposition to confirm the previous Acknowledgement remains in effect. CMS will work directly with the State Reviewer and the issuer on any compliance issues identified.