Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: April 13, 2017

This Agency is committed to returning to states their traditional authority to regulate health plans. We seek to ensure that policies empower states to make decisions that work best for their markets, understanding there are differences in markets from state to state. We will support state flexibility and control to create a free and open health care market in accordance with current statute. In accordance with that aim, this document provides guidance on qualified health plan (QHP) certification.

Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later

The Affordable Care Act and applicable regulations establish that health plans must meet certain standards to be certified as Qualified Health Plans (QHPs). For Federally-facilitated Marketplaces (FFMs), CMS certifies a plan as a QHP if it determines that the plan meets all applicable QHP certification standards. CMS currently allows states to assume primary responsibility for many of the functions of a Marketplace, including plan management functions, or to use a model where CMS performs plan management functions. The *2018 Letter to Issuers in the Federally-facilitated Marketplaces* provides an overview of the certification process in FFM states, including states performing plan management functions and making QHP certification recommendations to CMS.[1]

In keeping with Executive Order 13765, which directs agencies to exercise all authority and discretion available to them to provide greater flexibility to states and cooperate with them in implementing healthcare programs,[2] this guidance amends the previously released *2018 Letter to Issuers in the Federally-facilitated Marketplaces* by outlining areas where CMS will rely, starting with plan year 2018, on state reviews of QHP certification standards for states with FFMs, including states with FFMs that perform plan management functions in partnership with CMS. We believe these changes will help streamline the QHP certification process and avoid duplicative federal and state efforts.

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[1] Final 2018 Letter to Issuers in the Federally-facilitated Marketplaces and February 17 Addendum, 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.
[2] Executive Order 13765 of January 20, 2017, https://www.federalregister.gov/documents/2017/01/24/2017-01799/minimizing-the-economic-burden-of-the-patient-protection-and-affordable-care-act-pending-repeal.

For FFM states that do not perform plan management functions, CMS reviews plan data submitted by issuers. CMS will continue to review QHP data for these states, but will rely on state review for licensure, good standing, and network adequacy as outlined below.

For FFMs in states performing plan management functions, CMS is legally obligated to make final certification determinations, but state certification decisions will be given great weight. For these states, CMS will continue to rely on state plan data review for QHP certification standards, including for service area and non-discrimination in prescription drug coverage and cost sharing. We will continue to review certain plan data relating to federal funds or plan display on HealthCare.gov, such as cost-sharing reduction structures, data integrity, and plan crosswalks. States performing QHP certification reviews may reasonably interpret the applicable QHP certification standards.

We intend to engage with state regulators, issuers, and other stakeholders to determine whether we can further streamline the QHP certification process by relying on additional state reviews in future plan years and the appropriate timeframe for implementing such changes.

Licensure and Good Standing

45 CFR 156.200 requires QHP issuers to be licensed and in good standing in each state in which the issuer offers health insurance coverage. States collect and maintain documentation on licensure and good standing. State regulators maintain records of whether an issuer possesses a license, certificate of authority, certificate of compliance, or equivalent form or document authorizing it to offer a product type in its service areas. For years prior to plan year 2018, CMS relied on state reviews of licensure and good standing in states performing plan management functions. For other FFM states, CMS previously conducted reviews of issuers' licensure and good standing as part of the QHP certification process.

For plan years 2018 and later, in FFM states, CMS will no longer review issuers' compliance with licensure and good standing standards, regardless of whether the state performs plan management functions, and will instead defer to state processes. Rather than reviewing issuers' documentation, CMS plans to confirm with state regulators that an issuer is licensed and in good standing before certifying the issuer's plans as QHPs. We expect this will reduce burden on issuers and promote deference to states' historical role in these areas.

Network Adequacy

45 CFR 156.230 requires that QHP issuers ensure their provider networks are sufficient in number and types of providers so that all services are accessible to enrollees without unreasonable delay. For years prior to plan year 2018, CMS relied on state reviews of network adequacy in states performing plan management functions. For other FFM states, CMS previously conducted reviews of issuers' network adequacy.

As with licensure and good standing, states have historically played a central role in assessing the adequacy of networks for health plans market-wide and are in the best position to establish and monitor these standards. In deference to states' role in this area, CMS has finalized an approach that generally defers the review of network adequacy standards to states.

Under the Market Stabilization Final Rule, for states with a network adequacy review process (regardless of whether the state otherwise performs plan management functions), CMS will no longer conduct network adequacy review, and will defer to state processes.

For issuers in states without the authority and means to conduct such reviews, CMS will rely on the issuer's accreditation (commercial, Marketplace, or Medicaid) from an HHS-recognized accrediting entity (National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care). If accreditation cannot be provided, CMS will require issuers to submit access plans. We plan to notify the issuers that are required to submit an access plan in order to have plans certified as QHPs.

Service Area

45 CFR 155.1055 requires Marketplaces to evaluate QHP service areas to ensure they meet specified criteria. For years prior to plan year 2018, CMS reviewed QHP service areas for FFM states regardless of whether the state performed plan management functions. Because issuers are bound by state service area requirements, states are in a unique position to review service areas and ensure that they comply not only with state requirements, but also Marketplace requirements. Consequently, CMS deference to service area review by states is an opportunity to reduce federal duplication of state action.

For plan years 2018 and later, CMS will not conduct active certification reviews of QHP service areas for states that perform plan management functions, and will defer to state processes. CMS will continue to review QHP service areas for FFM states that do not perform plan management functions.

Prescription Drug Formulary Outliers & Non-Discrimination in Cost Sharing

45 CFR 156.125 and 156.225 prohibit QHP issuers from utilizing marketing practices or benefit designs that discriminate based on individuals' significant health needs or other specified factors. For plan years prior to plan year 2018, CMS reviewed QHP prescription drug practices and cost-sharing amounts for some states that performed plan management functions. CMS conducted the prescription drug reviews by identifying plan formularies with an unusually low number of drugs not subject to prior authorization or step therapy. We conducted the cost sharing reviews by finding plans with co-pays or co-insurance that were outliers compared to other plans. CMS provided states with tools that allow them to conduct similar reviews.

For plan years 2018 and later, CMS will not conduct active certification reviews for prescription drug formulary and cost sharing outliers for states that perform plan management functions, and instead will defer to those state processes. CMS will continue to review for prescription drug formulary and cost sharing outliers for FFM states that do not perform plan management functions.