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: 2023 Letter to Issuers in the Federally-facilitated Exchanges[1]

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2023 Draft Letter to Issuers in the Federally-facilitated Exchanges (2023 Draft Letter). This 2023 Draft Letter provides updates on operational and technical guidance for the 2023 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 2023 Draft Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2023. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2023 Draft Letter focuses on guidance that has been updated for the 2023 plan year, and refers issuers to the 2017 through 2022 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.[2] CMS notes that the policies articulated in this 2023 Draft Letter would apply to the QHP certification process for plan years beginning in

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

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

2023.[3] Throughout this 2023 Draft Letter, CMS identifies the areas in which states performing plan management functions in the FFEs have flexibility to follow an approach different from that articulated in this proposed 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 2023 Draft Letter are to Title 45 of the CFR.[4] While certain parts of the 2023 Draft Letter explain associated regulatory requirements, the 2023 Draft Letter is not a complete list of regulatory requirements for issuers.

CMS welcomes comments on this proposed guidance. To the extent this guidance summarizes policies proposed through other rulemaking processes that have not yet been finalized, such as the rulemaking process for the proposed 2023 Payment Notice,[5] stakeholders should comment on those underlying policies through the ongoing rulemaking processes, and not through the comment process for this Letter. Please send comments on other aspects of this 2023 Draft Letter to PMpolicy@cms.hhs.gov by January 27, 2022. Comments will be most helpful if organized by the subsections of this 2023 Draft Letter.

[3] Plan years in the FF-SHOPs will not always align with calendar year 2023.
[4] *Available at:* https://ecfr.federalregister.gov/current/title-45.
[5] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584 (January 5, 2022), *available at*: https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf.

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

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

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

This chapter provides an overview of the QHP certification process. This process applies to all states in which an FFE operates, which include (1) states performing plan management functions and making QHP certification recommendations to CMS, (2) states where CMS is performing all plan management functions and certifying QHPs while the state is enforcing the market-wide standards under the ACA, and (3) direct enforcement states[6] where CMS is performing plan management functions and enforcing market-wide standards under the ACA (but the state continues to enforce state law requirements with which issuers must comply).[7] Additional information and instructions about the process for issuers to complete a QHP application can be found at https://www.qhpcertification.cms.gov.

Section 1. QHP Certification Process

CMS expects issuers and state regulatory authorities in states with Exchanges using the federal platform applying for QHP Certification to adhere to the plan year 2023 QHP Data Submission Timeline.[8]

Issuers will submit a complete QHP application for plans they intend to have certified in a state in which an FFE is operating. The "Early Bird" QHP Application submission window is an optional submission window for issuers to submit application data prior to the first formal submission deadline. CMS will review and return results on these data as available prior to the first submission deadline, and if any changes are made in response to CMS-identified needed corrections, CMS will not flag it as a correction in the full review round.

CMS will review QHP applications for all issuers applying for QHP certification in an FFE[9] and notify issuers of any need for corrections after each round of review. After the final QHP

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[6] The list of direct enforcement states is *available at:* https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html.

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

[8] *See* Proposed Plan Year 2023 QHP Data Submission Timeline (November 23, 2021) *available at:* https://www.cms.gov/files/document/Proposed-PY2023-QHP-Data-Submission-Certification-Timeline-Bulletin.pdf. All dates are subject to change.

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

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.

CMS will post a list of plans received and reviewed during the QHP application process in each issuer's profile in the CCIIO Plan Management Community (PM Community). Each issuer will access the plan list and confirm their plans within the PM Community. If an issuer wishes to withdraw a plan from consideration in the QHP Certification process, or to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration, the issuer must follow the plan withdrawal process provided by CMS. An issuer's final plan confirmation to CMS is generally the last opportunity for the issuer to withdraw a plan from certification consideration for the upcoming plan year.

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

Issuers may have their QHP application denied if they fail to meet the deadlines in the plan year 2023 QHP Data Submission Timeline, or if their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.[11]

Section 2. QHP Application Data Submission

CMS requires issuers, including SADP issuers, to submit complete QHP applications by the initial submission deadline in the plan year 2023 QHP Data Submission Timeline and to make necessary updates to the QHP application prior to the last deadline for issuer submission. Additionally, issuers must comply with any CMS requirements related to rate filings. There are certain states where CMS is directly performing rate review as well as enforcing other applicable Public Health Service Act (PHS Act) requirements. To see the enforcement stance in states, on a provision by provision basis, please review the state enforcement letters at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA. CMS updates these letters on a rolling basis and expects to have all state enforcement letters posted soon.

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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.

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

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

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.[12] All issuers must also register for the PM Community to receive correction and certification notices, as well as other relevant communications regarding their QHP applications.[13]

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

All issuers applying for QHP certification must access the Plan Preview environment to review plan benefit data and identify and correct data submission errors before the QHP application data submission deadline. Issuers can use Plan Preview to check their plan data display for most enrollment scenarios, including service areas, cost sharing for benefits, and URLs (including payment redirect). Issuers will use the Plan Preview environment to verify that their plan display reflects their state-approved filings. Issuers in states performing plan management functions in the FFEs will be able to view their plan data after the state transfers QHP data from SERFF to HIOS. To use Plan Preview, issuers must first submit rates data to CMS. CMS encourages issuers to review the data in Plan Preview throughout the QHP certification process to ensure that the plan benefit data are correct.

Discrepancies between an issuer's QHP application and approved state filings may result in a plan not being certified, or if CMS has already certified a plan as a QHP, decertification or other appropriate compliance or enforcement action. All issuers must complete quality assurance

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[12] *See* additional information on HIOS registration, which is contained in the HIOS Portal User Manual. The HIOS Portal User Manual is *available at:* https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Content%20Requirements%20for%20Plan%20Finder. CMS expects issuers to use the same HIOS plan identification numbers for plans, including SADPs, submitted for certification for plan year 2023 that are the same as plans, including SADPs, certified as QHPs for plan year 2022, as defined in 45 CFR 144.103 and pursuant to 45 CFR 147.106. While 45 CFR 147.106 is not applicable to issuers of SADPs, CMS expects SADP issuers to use the same HIOS plan identification numbers for plans submitted for certification for plan year 2023 that are the same plan as SADPs certified for plan year 2022, even if they have been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value. The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to 45 CFR 155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for plan year 2023 that had been certified for plan year 2022, the issuer is subject to the standards outlined in 45 CFR 156.290.

[13] For issuers not currently participating in the PM Community, in spring 2022 CMS intends to make instructions available on how to enroll to receive information for the plan year 2023 QHP application period.

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

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

activities to ensure the completeness and accuracy of QHP application data, including reviewing plan data in the Plan Preview environment.

Section 3. QHP Data Changes

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

Table 1.1 outlines the parameters under which issuers may change their submitted QHP data. Issuers may make changes to their QHP applications without state or CMS authorization until the deadline for initial application submission. After the close of the initial QHP application submission window, issuers may not add new plans to a QHP application or change an off-Exchange plan to be both on and off-Exchange. Issuers also may not change plan type(s) or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to state or CMS feedback until the deadline for issuer changes. For all other changes, issuers are also not required to submit data change requests or document state authorization to CMS. 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 where noted.	N/A	Issuers may not: Add new plans to a QHP application; Change an off- Exchange plan to be both on and off-Exchange; Change plan type(s) or market type; or Change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan.
After the Final Submission Deadline	N/A	Issuers may request critical data changes to align with state filings. URLs may be changed with state authorization; CMS authorization is not required.	Issuers may not change certified QHP data without the explicit direction and authorization of CMS and the state.

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

To withdraw a plan from QHP certification consideration, an issuer must follow the plan withdrawal process as outlined by CMS at https://www.qhpcertification.cms.gov. After

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

After the deadline for issuer changes to QHP applications, issuers will only make corrections directed by CMS or by their state. States may direct changes by contacting CMS with a list of requested corrections. Issuers whose applications are not accurate after the final deadline for issuer submission of changes to the QHP application, and are then required to resubmit corrected data during the limited data correction window, may be subject to compliance action by CMS.[16] Issuer changes made in the limited data correction window not approved by CMS and/or the state may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

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

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

Section 4. QHP Review Coordination with States

Each state will define the relevant submission window for state-level reviews as well as dates and processes for corrections and resubmissions. CMS will rely on states' reviews of issuer-submitted policy forms and rate filings for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines.[17] States that have

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

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

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

When states perform QHP certification reviews,[19] they may exercise reasonable flexibility in their application of CMS' QHP certification standards, provided that the state's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in states that are performing plan management functions in the FFEs should continue to refer to state direction in addition to this guidance.

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

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

For states performing plan management functions in the FFEs, the SERFF data transfer deadlines will align with the HIOS submission deadlines. These state transfers should include all plans submitted to the state for certification, including SADPs for off-Exchange sale.[20] CMS understands that all state reviews might not be complete by the submission deadlines, but as stated above, requires state confirmation of approval of QHPs for sale prior to CMS certification.

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

[18] *See* Center for Consumer Information and Insurance Oversight, CMS, Draft Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2022 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2023 (November 23, 2021), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-Rate-Review-Bulletin-for-CY2022.

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

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

prior to 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 2022 plan year. Please refer to the 2018 Letter to Issuers for more information regarding submission requirements pertinent to the Plan ID Crosswalk. The 2023 certification approach for alternate enrollments also remains unchanged from 2018 and later years for QHPs that are not SADPs. SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, CMS aims to apply the processes established for the 2022 plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for plans offered during the 2023 plan year.

Section 6. Value-based Insurance Design

The approach for 2023 remains unchanged from 2021 and 2022. Please refer to the 2021 Letter to Issuers in the Federally-facilitated Exchanges (2021 Letter to Issuers) for more information.

Section 7. Alternative Payment Models (APMs)

The approach for 2023 remains unchanged from 2022 as CMS continues to encourage issuers and states to advance efforts to support value-based care and value-based payments across the health care system, with a particular emphasis on the individual market population. Please refer to the 2022 Letter to Issuers for more information and for some possible pathways for adoption of such approaches.

The CMS Center for Medicare & Medicaid Innovation (Innovation Center)'s vision for the next decade is a health system that achieves equitable outcomes through high quality, affordable, person-centered care. The five strategic objectives that will guide the Innovation Center's implementation of this vision are: drive accountable care, advance health equity, support care innovations, improve access by addressing affordability, and partner to achieve system transformation.[21] In addition to value-based insurance design, one such approach is alignment with APMs through the Innovation Center. As part of the objective to partner to achieve system transformation, the Innovation Center is collaborating with other payers and/or states to amplify the impacts of models across Medicare and Medicaid, as well as commercial payers where possible. Providers have found that multi-payer alignment can make it easier to transition to and sustain participation in value-based care. More information can be found on the Innovation Center website.[22]

Section 8. Issuer Participation for the Full Plan Year

The approach for 2023 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

[21] *Available at:* https://innovation.cms.gov/strategic-direction.
[22] *See* Innovation Models *available at*: https://innovation.cms.gov/innovation-models#views=models.

Section 9. Standardized Options

In the 2023 Payment Notice, CMS proposes to require issuers of QHPs in FFEs and SBE-FPs, for plan years 2023 and beyond, to offer through the Exchange standardized QHP options at every product network type, as the term is used in the definition of "product" defined at § 144.103, metal level, and throughout every service area that they offer non-standardized QHP options. For example, if an FFE issuer offers a non-standardized gold HMO QHP in a particular service area, that same issuer must also offer a standardized gold HMO QHP throughout that same service area. The standardized QHP option plan designs that CMS proposes FFE and SBE-FP issuers be required to offer for plan years 2023 and beyond are specified in the discussion of §156.201 in the preamble to the 2023 Payment Notice. CMS does not propose to limit the number of non-standardized QHP options that issuers of QHPs in FFEs and SBE-FPs can offer through the Exchange in plan year 2023.

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

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

This Chapter provides an overview of key QHP certification standards for both QHPs and SADPs in FFEs, including those in states performing plan management functions, and how CMS or the state will evaluate and conduct reviews of 2023 QHPs and SADPs for compliance.

Section 1. Licensure and Good Standing

The approach for licensure and good standing remains unchanged from 2018 and later years. Please refer to the Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for plan years 2018 and Later ("State Guidance on QHP Reviews") for more information.[23] 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 2018 and later years. Guidance for submitting service area changes will be released at a later date. Please refer to the 2018 Letter to Issuers for more information.

[23] *See* Center for Consumer Information and Insurance Oversight, CMS, Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces 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.

Section 3. Network Adequacy

This section describes how in the 2023 Payment Notice CMS proposes to conduct reviews of the network adequacy standards for medical QHP and SADP certification. Pursuant to 45 C.F.R. 156.230(a)(2), an issuer of a QHP that has a provider network 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 ensure that all services will be accessible to enrollees without unreasonable delay.

As described in the 2023 Payment Notice, CMS proposes to evaluate QHPs for compliance with network adequacy standards based on time and distance standards and appointment wait time standards. CMS also proposes in the 2023 Payment Notice to clarify that, for plans that use tiered networks, to count toward the issuer's satisfaction of network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. Finally, in the 2023 Payment Notice, CMS proposes to collect from QHPs information on whether providers participating in their network offer telehealth services. CMS will continue to coordinate closely with state authorities to address network adequacy compliance issues, eliminate duplicative requirements or reviews, and reduce stakeholder burden.

i. FFE Network Adequacy Reviews

In the 2023 Payment Notice, CMS proposes to evaluate network adequacy for plans to be offered as QHPs through the FFEs except for in certain states. States performing plan management functions are states served by an FFE where the state has agreed to assume primary responsibility for reviewing issuer-submitted QHP certification material and making certification recommendations to CMS. CMS would not evaluate QHP network adequacy in states performing plan management functions that elect to perform their own reviews of plans seeking QHP certification in their state, so long as the state applies and enforces quantitative network adequacy standards that are at least as stringent as the federal network adequacy standards established for QHPs under 45 C.F.R. 156.230, and that reviews are conducted prior to QHP certification. Issuers in all FFE states, including states performing plan management functions, would need to submit their network adequacy data to CMS via the Essential Community Provider/Network Adequacy (ECP/NA) template.

ii. Network Adequacy for QHP Issuers in FFEs

a. Time and Distance Standards

Similar to our approach in prior years, CMS proposes to adopt time and distance standards to assess whether QHPs in FFEs fulfill the network adequacy regulatory requirement. Tables 3.1 and 3.2 list the proposed time and distance standards for medical QHPs and the provider types to which they apply. For medical QHPs, CMS would only assess compliance for the dental provider type for those medical QHPs that have embedded dental services as a benefit. For SADPs, table 3.3 lists the proposed time and distance standard for the dental provider type.

To count towards meeting the time and distance standard, individual and facility providers listed on Tables 3.1, 3.2, and 3.3 would have to be appropriately licensed, accredited, or certified to practice in their state, as applicable, and would need to have in-person services available.

Taxonomy codes that filter into each individual provider and facility specialty type would be listed in the ECP/NA template and the QHP Issuer Application Instructions so that issuers know which providers to include in which individual and facility specialty categories. For brevity purposes, when discussing provider types for network adequacy, we will use the term "behavioral health" to encompass mental health and substance use disorders. Under the circumstances described below, advanced practice registered nurses (APRNs) and physician assistants (PAs) could be included as primary care providers, and APRNs who specialize in behavioral health services could be included in the outpatient clinical behavioral health provider category. The purpose of including these specialties is to inform CMS of the rare times contracting with non-MD/DO primary care and behavioral health services providers in underserved counties is necessary to serve as the major source of these types of care for enrollees. Organizations may include submissions under this specialty code only if the contracted APRN or PA is currently licensed in the state, meets the state's requirements governing the qualifications of that provider type, and is fully credentialed by the organization as a provider of primary care or behavioral health services. In addition, to count towards meeting the time and distance standard, the providers listed under this specialty code must function in accordance with state law as the primary source for the enrollee's primary care or behavioral health services, not supplement a primary care physician's care, and be practicing in or rendering services to enrollees residing in a Health Professional Shortage Area[24].

CMS proposes to assess time and distance standards at the county level. In alignment with Medicare Advantage's approach, CMS would classify counties into five county type designations: Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC). CMS would use a county type designation method that is based upon the population size and density parameters of individual counties. These parameters are foundationally based on approaches used by the Census Bureau in its classification of "urbanized areas" and "urban clusters," and by the Office of Management and Budget in its classification of "metropolitan" and "micropolitan." For the population and density parameters, see pages 6-7 of the Medicare Advantage Network Adequacy Criteria Guidance.[25]

Table 3.1 Time and Distance Standards for Individual Provider Specialty Types for Medical QHPs for Exchange Plan Year 2023 Certification.

Individual Provider Specialty Types	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110

[24] *Available at:* https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas.
[25] *Available at:* https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

Individual Provider Specialty Types	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care – Adult	10	5	15	10	30	20	40	30	70	60
Primary Care – Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130

Table 3.2 Time and Distance Standards for Facility Specialty Types for Medical QHPs for Exchange Plan Year 2023 Certification.

Facility Specialty Type	Maximum Time and Distance Standards									
	Large County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (Must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

Table 3.3 Time and Distance Standards for SADPs for Exchange Plan Year 2023 Certification.

Individual Provider Specialty Type	Maximum Time and Distance Standards									
	Large County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

To assess whether QHPs comply with these standards, CMS proposes to review provider data for in-network providers that QHP issuers submit in the ECP/NA template. For each specialty and standard listed in the table, CMS would review the issuer-submitted data to ensure that the plan provides access to at least one provider in each of the above-listed provider type categories for at least 90 percent of enrollees. For example, for endocrinology in a large metro county type, at least 90 percent of enrollees would be required to have reasonable access to at least one provider within 15 miles or 30 minutes.

If the 2023 Payment Notice is finalized as proposed, when CMS determines that a QHP does not meet one or more time and distance standards, the issuer would have two options: 1) add more contracted providers to the network to come into alignment with the standard, or 2) submit a completed Network Adequacy Justification Form. The justification process would require issuers that do not yet meet the time and distance standards to detail: the reasons that one or more time and distance standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types; information regarding enrollee complaints regarding access to the respective provider specialty types; and the issuer's efforts to recruit additional providers. CMS would use any updated provider data and the completed Network Adequacy Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, prior to making the certification decision. CMS would continue to monitor network adequacy throughout the year and would coordinate with state Departments of Insurance should it be necessary to remedy potential deficiencies.

b. Appointment Wait Times

CMS proposes to adopt for QHPs on the FFEs appointment wait time standards to assess whether QHPs offered through the FFEs fulfill network adequacy standards applicable to plans that use a provider network. See Table 3.4 for the list of provider specialties and parameters. Appointment wait time standards would apply to medical QHPs. For SADPs, only the dental provider specialty within the Specialty Care (Non-Urgent) category of appointment wait time standards would apply. To count towards meeting appointment wait time standards, providers listed in Table 3.4 must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available. Taxonomy codes that filter into each provider and facility specialty type would be listed in the ECP/NA template and the QHP Issuer Application Instructions. Issuers would be required to meet the below standards 90 percent of the time at a minimum.

Table 3.4 Appointment Wait Time Standards for Exchange Plan Year 2023 Certification.

Provider/Facility Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 calendar days
Primary Care (Routine)	15 calendar days
Specialty Care (Non-Urgent)	30 calendar days

If finalized as proposed, issuers would be required to attest to satisfying appointment wait time standards. When making the attestation, issuers would consider only appointment wait times for in-network providers. QHP issuers that do not currently collect this information may do so using the same means and methods by which they already collect information from their in-network providers, which could include provider surveys or secret shopping. CMS would conduct compliance reviews in response to access to care complaints or through random sampling.

If the 2023 Payment Notice is finalized as proposed, when an issuer does not attest to meeting appointment wait time standards, the issuer would have the same options as when not meeting time and distance standards: 1) add more contracted providers to the network to come into alignment with the standard, or 2) submit a completed Network Adequacy Justification Form. The justification process would require issuers that do not yet meet the appointment wait time standards to detail the same information described in the time and distance standard section above. CMS would use any updated provider data and completed Network Adequacy

Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, prior to making the certification decision. CMS would continue to monitor network adequacy throughout the year and would coordinate with state Departments of Insurance should it be necessary to remedy potential deficiencies.

c. Tiered Networks

If the 2023 Payment Notice is finalized as proposed, for plan year 2023 plans that use tiered networks to count toward the issuer's satisfaction of the network adequacy standards, those plans' providers must be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees. For example, a QHP issuer could not use providers contracted with their PPO network when certifying their HMO network, if use of PPO network providers would result in higher cost sharing obligations for HMO plan enrollees. For plans with two network tiers (such as participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only the preferred network would be counted towards satisfying network adequacy standards.

iii. Telehealth Services

If the 2023 Payment Notice is finalized as proposed, for plan year 2023, CMS would collect from QHPs via the ECP/NA template information on whether providers participating in their network offer telehealth services. For each provider, issuers would indicate yes or no to whether that provider offers telehealth. For this purpose, CMS is defining telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation." As proposed in the 2023 Payment Notice, CMS proposes that issuers who do not already have data on whether their providers offer telehealth would need to collect this information prior to QHP certification. QHP issuers that do not currently collect this information may do so using the same means and methods by which they already collect information from their network providers relevant to time and distance standards and provider directory information. Issuers who do not have the information available by the time of the QHP certification process would be able to respond that they have requested the information from the provider and are awaiting the response. For plan year 2023, these data would inform network adequacy standards for future plan years and would not be made available to the public.

iv. Network Transparency

This section discusses how CMS will label each QHP network's breadth as compared to other QHP networks on HealthCare.gov. This section applies to all QHP issuers in states participating in the network breadth pilot, including where the state is performing plan management functions and SBE-FPs, but excludes SADPs. This information will be available to consumers to provide them with information on a network's relative breadth. The purpose of the labeling is to provide increased transparency to enrollees about the breadth of the provider network in the coverage they are selecting.

For plan year 2023, each network's breadth will be compared to the network breadth of other QHPs available in the same geographic area. CMS will identify network breadth based on analysis of QHP provider and facility data submitted as part of the plan year 2023 certification process via the ECP/NA template. This analysis will compare an issuer's contracted providers to the number of specific providers and facilities included across all QHP networks available in a

county. The rating will focus on hospitals, adult primary care, and pediatric primary care with a separate classification for each of the three categories. The classifications of network breadth for each plan will be at the county level.

CMS will determine these classifications by calculating the percentage of providers in a plan's network compared to the total number of providers in QHP networks available in a county based on a time and distance calculation. To calculate network breadth, CMS will divide the number of each QHP's servicing providers at the issuer, network, county, and specialty combination level by the total number of all available QHP servicing providers for that county, including ECPs. The resulting number will be the Provider Participation Rate (PPR).

CMS classifies networks that contain:

- fewer than 30 percent of available providers as Basic;
- 30−69 percent of available providers as Standard; and
- 70 percent or more of available providers as Broad.

Section 4. Essential Community Providers

The Essential Community Provider (ECP) standard for the 2023 plan year and the approach for reviews of the ECP standard, as proposed in the 2023 Payment Notice, would be the same as for the 2022 and 2021 plan years, with the exception of the changes noted below.[26] Please refer to the 2018 Letter to Issuers for full details.

At 45 CFR 156.235, CMS established QHP issuer requirements for inclusion of ECPs in provider networks, which provides the basis of the percent threshold requirement that issuers include at least a certain percentage, as determined by the Department of Health and Human Services (HHS), of available ECPs (based on a non-exhaustive HHS ECP List provided to issuers and updated annually) within the plan's service area in the issuer's provider network(s). The calculation methodology outlined in the 2018 Letter to Issuers and 2018 Payment Notice would remain unchanged for issuers offering plans with a provider network.

As proposed in the 2023 Payment Notice, for plan year 2023 and beyond, CMS proposes to increase the required threshold from 20 percent to 35 percent of available ECPs in the plan's service area, including approved ECP write-ins that would also count toward the issuer's satisfaction of the 35 percent threshold.

For plan year 2021, the percentage of medical and dental FFE issuers that could have satisfied a 35 percent ECP threshold was 80 percent and 74 percent, respectively; while the mean and median ECP score across all FFE issuers was 55 percent and 54 percent, respectively. Given that during the 2015-2017 plan years, all issuers satisfied the 30 percent standard when permitted to supplement their QHP applications with ECP write-ins and justifications, CMS anticipates that any issuers falling shy of the 35 percent threshold for the 2023 plan year could satisfy the standard by relying on these same supplemental aids.

If the 2023 Payment Notice is finalized as proposed, when CMS determines that a QHP does not meet ECP standards, the issuer would have two options: 1) add more contracted providers to the network to come into alignment with the standard, or 2) submit a completed ECP Justification

[26] The ECP Petition is *available at:* https://data.healthcare.gov/cciio/ecp_petition.

Form. The justification process would require issuers that do not yet meet the ECP standards to detail: the reasons that one or more ECP standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to ECPs; information regarding enrollee complaints regarding access to ECPs; and the issuer's efforts to recruit additional ECPs. CMS would use any updated provider data and the completed ECP Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, prior to making the certification decision.

For issuers needing to submit an ECP Justification Form, CMS would be accepting only the official ECP Justification Form and would no longer be accepting individually customized supplemental response forms as a substitute for the official form. The issuer should choose the applicable form among the following versions:

- ECP Justification Form for Medical QHPs submitting under the General ECP Standard
- ECP Justification Form for Medical QHPs submitting under the Alternate ECP Standard
- ECP Justification Form for SADPs submitting under the General ECP Standard
- ECP Justification Form for SADPs submitting under the Alternate ECP Standard

If the 2023 Payment Notice is finalized as proposed, for plans that use tiered networks, to count toward the issuer's satisfaction of each element of the ECP standard, ECPs would have to be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees. For example, a QHP issuer could not use the number of ECPs contracted with their PPO network when certifying their HMO network, if use of the PPO network providers would result in higher cost-sharing obligations for HMO plan enrollees. For plans with two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only the preferred network would be counted towards satisfying the ECP standards. The elements of the ECP standard are: contracting with a minimum of 35 percent of available ECPs in the plan's service area; offering contracts in good faith to all available Indian health care providers; and offering contracts in good faith to at least one ECP in each ECP category in each county in the service area.

Additionally, for the 2023 plan year and beyond, CMS has added Substance Use Disorder Treatment Centers under the category of Other ECP Providers, as these facilities are critical to CMS's efforts to ensure that low-income, medically underserved individuals have sufficient access to these providers.

Section 5. Accreditation

The approach for reviews of the accreditation standard remains largely unchanged from 2020. In continued consideration of the announcements by HHS-recognized accrediting entities making modifications to accreditation standards due to the COVID-19 public health emergency,[27] CMS may provide flexibilities with regard to health plan accreditation reviews, as appropriate. HHS encourages issuers to provide their accrediting entity (AE) their HIOS ID number associated with their organization as they begin to work with the AE(s) on accreditation.

[27] *See* announcements *available at:* https://www.ncqa.org/covid/, https://www.urac.org/press-room/urac-responds-coronavirus, and https://www.aaahc.org/what-you-need-to-know/.

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards remains unchanged from 2017 and later years. Please refer to the 2017 Letter to Issuers in the Federally-facilitated Exchanges (2017 Letter to Issuers) for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds. CMS will continue to assess these standards and any related burden for issuers and hospitals.

Section 7. Quality Reporting

The approach for review of QHP issuer compliance with quality reporting standards related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey) remains unchanged[28] 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 2022[29] for more detailed information on issuer data collection and reporting requirements for the 2022 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.[30] 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 2023 plan year.

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

Section 9. Review of Rates

The approach for 2023 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]

[28] The suspension of activities related to the collection of clinical quality measures for the QRS and survey measures for the QHP Enrollee Survey noted in the 2021 Letter to Issuers was specific to the 2021 plan year (2020 ratings year).
[29] *See* Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022 (October 2021), *available at:* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.
[30] The suspension of reporting QIS data noted in the 2021 Letter to Issuers was specific to the 2021 plan year (2020 calendar year).
[31] *See* the 2022 Unified Rate Review Instructions, *available at*: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/URR%20v5.3%20instructions.pdf.

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, QHP discriminatory benefit design, and the treatment protocol calculator. However, the 2023 Payment Notice would refine the essential health benefits (EHB) nondiscrimination policy for health plan designs. If finalized as proposed, CMS will assess compliance of QHPs in the FFEs by ensuring consistent application of EHB nondiscrimination policy, which will better safeguard consumers who depend on nondiscrimination protections, such by as prohibiting discrimination based on sexual orientation and gender identity.[32] While states are generally the primary enforcers of EHB policy, CMS will continue to monitor issuer compliance with EHB nondiscrimination policy and provide technical assistance and available data, research, or other information to states. CMS will assess benefit designs to ensure they are nondiscriminatory and consistent with 45 CFR 156.125, regardless of how a discriminatory benefit design originated.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from 2019 and later years. For the 2023 plan year, asthma will be added as a condition to the clinical appropriateness review. Please refer to the 2019 Letter to Issuers in the Federally-facilitated Exchanges (2019 Letter to Issuers) for more information.

Section 12. Third Party Payment of Premiums and Cost Sharing

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

Section 13. Cost-sharing Reduction Plan Variations

The approach for issuers to provide cost-sharing reductions (CSRs) to consumers through CSR plan variations remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information. Eligible consumers can enroll in these plan variations for the 2023 plan year and will continue to receive CSRs provided by issuers. Beginning October 2017 and beyond, CMS has not made and cannot make CSR payments to issuers, unless Congress appropriates funds for these payments.

Section 14. Data Integrity Review

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

[32] *See* Executive Order 13988 on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, 86 FR 7023 (Jan. 20, 2021).

Section 15. Interoperability

The Interoperability and Patient Access Final Rule[33] was finalized on May 1, 2020. For plan year 2023, the policy remains unchanged from plan year 2022. To assess compliance with all interoperability requirements, the FFEs will require QHP issuers to attest that they are meeting the requirements at 45 CFR 156.221 or submit a justification as part of the QHP application. Please refer to the 2022 Letter to Issuers for more information on previous interoperability requirements. As noted in the final rule, the interoperability requirements specifically exclude QHP issuers on the FFEs offering only SADPs or issuers only offering QHPs in the FF-SHOPs.

As noted in the Notification of Enforcement Discretion released on December 10, 2021,[34] CMS has opted to employ enforcement discretion for 45 CFR 156.221(f), known as the payer-to-payer data exchange provision, which instructs issuers to maintain a process for the electronic exchange of data classes and elements with other payers for current and prior enrollees. Enforcement of the payer-to-payer data exchange requirement is delayed and will not be incorporated in QHP certification for plan year 2023. QHP issuers are encouraged to review the Federal Register notice referenced above announcing enforcement discretion for more information.

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, 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 see 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.

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

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

Pursuant to 45 CFR 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection, CMS-10572, "Transparency in Coverage Reporting by Qualified Health Plan Issuers," Paperwork Reduction Act (PRA) to OMB for an additional 3-year collection period, and it is pending OMB approval. If approved, the data collection elements that QHP issuers reported from 2020 to 2022 would remain part of the collection for the 2023 plan year. Transparency in Coverage URL submissions should be made in the QHP Supplemental Submission Module at the time of QHP application submission.

Section 3. Medical Cost Scenarios

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

CHAPTER 4: STAND-ALONE DENTAL PLANS: 2023 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 2021. Please refer to the 2018 and 2021 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For plan year 2023, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 12.696 percentage point increase of the Consumer Price Index (CPI) for dental services of 516.519 for 2021 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $44.44 to a total of $394.44. 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 plan year 2023 will be $375 for one child and $750 for two or more children. For more information on how this limitation is determined, please refer to § 156.150 and to the 2018 Letter to Issuers.

Section 2. SADP Actuarial Value Requirements

The approach to actuarial value requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021. For plan year 2023, SADP issuers may offer the pediatric dental EHB at any actuarial value. SADP issuers will be required to certify the actuarial value of each SADP's coverage of pediatric dental EHB.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

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

Guidance on QHP issuer account management, issuer compliance monitoring, issuer compliance reviews, and issuer participation for the full plan year generally remains unchanged from 2018

and later years. Please refer to the Letter to Issuers from 2018 and letters from later years for more information.

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 remain unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

However, please note that PHS Act section 2719, as amended by title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and implemented through interim final rules published on October 7, 2021[35] amends the scope of claims eligible for external review to include adverse benefit determinations related to compliance with the surprise billing and cost-sharing protections under sections 2799A-1 or 2799A-2 of the PHS Act, as added by the No Surprises Act. The interim final rules also extend the external review requirement to grandfathered health plans for adverse benefit determinations involving items and services covered by the requirements of PHS Act sections 2799A-1 or 2799A-2.

Section 2. Consumer Case Tracking

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

Section 3. Meaningful Access

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

In the 2018 Payment Notice, CMS finalized changes to the tagline requirements applicable to Exchanges and QHP issuers pursuant to section 1311 of the ACA (1311 tagline requirements), as implemented at 45 CFR 155.205(c)(2)(iii)(A), with the intent to reduce overlapping regulatory burden on Exchanges and QHP issuers in relation to tagline requirements.[36] This rule stated that Exchanges and QHP issuers will be deemed to be in compliance with 45 CFR 155.205(c)(2)(iii)(A) if they are in compliance with 45 CFR 92.8.

In June 2020, HHS published a final rule[37] eliminating 45 CFR 92.8, and the section 1311 tagline requirements. Nonetheless, section 1557 of the ACA, Title VI of the Civil Rights Act of

[35] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (Oct. 7, 2021).
[36] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 94058 (December 22, 2016), *available at*: https://www.govinfo.gov/content/pkg/FR-2016-12-22/pdf/2016-30433.pdf.
[37] Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37160 (June 19, 2020), *available at*: https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-11758.pdf.

1964 (Title VI), and Section 504 of the Rehabilitation Act still require covered entities to take reasonable steps to ensure meaningful access to their programs by LEP individuals and individuals with disabilities. Therefore, in some cases, the provision of notices and taglines may be necessary to ensure meaningful access by LEP individuals and individuals with disabilities.

Additionally, in light of priorities to improve health equity and remove potential barriers that underserved communities and individuals may face to enrollment in and access to benefits in federal programs, we strongly encourage QHP issuers and Exchanges to continue to meet tagline standards as set forth in the 2018 Letter to Issuers. HHS intends to issue future rulemaking proposing to reaffirm and clarify these standards as requirements.

Section 4. Summary of Benefits and Coverage

The guidance on the Summary of Benefits and Coverage remains unchanged. Please refer to the 2022 Letter to Issuers for more information.

CHAPTER 7: TRIBAL RELATIONS AND SUPPORT

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

CMS guidance concerning Indian health care providers remains unchanged from 2018 and later years. For more information, please refer to the 2018 Letter to Issuers.[38]

[38] The model QHP Addendum for Indian health providers is *available at*: http://www.cms.gov/cciio/programs-andinitiatives/health-insurance-marketplaces/qhp.html.