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

**Title: 2024 Final Letter to Issuers in the Federally-facilitated Exchanges<sup>1</sup>**

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2024 Final Letter to Issuers in the Federally-facilitated Exchanges (2024 Final Letter). This 2024 Final Letter provides updates on operational and technical guidance for the 2024 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFE) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of this 2024 Final Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2024. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2024 Final Letter focuses on guidance that has been updated for the 2024 plan year, and refers issuers to the 2017 through 2023 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.<sup>2</sup> CMS notes that the policies articulated in

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<sup>1</sup> 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.

<sup>2</sup> 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](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers_022916.pdf); Center for Consumer Information and Insurance Oversight, CMS, Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 17, 2017), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>; Center for Consumer Information and Insurance Oversight, CMS, 2019 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 9, 2018), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf>; Center for Consumer Information and Insurance Oversight, CMS, 2020 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 18, 2019), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2021 Letter to Issuers in the Federally-facilitated Marketplaces (May 7, 2020), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2022 Letter to Issuers in the Federally-facilitated Marketplaces (May 6, 2021), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>; Center for Consumer Information and Insurance Oversight, CMS, Final 2023 Letter to Issuers in the Federally-facilitated Marketplaces (April 28, 2022), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf>.

this 2024 Final Letter apply to the QHP certification process for plan years beginning in 2024.<sup>3</sup> Throughout this 2024 Final Letter, CMS identifies the areas in which States performing plan management functions in the FFEs have flexibility to follow an approach different from that articulated in this guidance.

Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics are set out in Title 45 of the Code of Federal Regulations (CFR) Subtitle A, Subchapter B. Unless otherwise indicated, regulatory references in this 2024 Final Letter are to Title 45 of the CFR.<sup>4</sup> While certain parts of the 2024 Final Letter explain associated regulatory requirements, the 2024 Final Letter is not a complete list of regulatory requirements for issuers.

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<sup>3</sup> Plan years in the FF-SHOPs will not always align with calendar year 2024.

<sup>4</sup> Available at: <https://ecfr.federalregister.gov/current/title-45>.

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## CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

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

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

This chapter provides an overview of the QHP certification process. This process applies to all States in which an FFE operates, which include (1) States performing plan management functions and making QHP certification recommendations to CMS, (2) States where CMS is performing all plan management functions and certifying QHPs while the State is enforcing the insurance market reforms in the Public Health Service (PHS) Act, and (3) States where CMS is performing all plan management functions and where the State does not enforce insurance market reforms added to the Public Health Service Act by the ACA,<sup>5</sup> or by Titles I and II (the No Surprises Act and Transparency Act) of Division BB of the Consolidated Appropriations Act, 2021.<sup>6</sup> 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 (PY) 2024 Qualified Health Plan (QHP) Data Submission and Certification Timeline.<sup>7</sup>

Issuers will submit a complete QHP application for plans they intend to have certified in a State in which an FFE is operating. CMS will review QHP applications for all issuers applying for QHP certification in an FFE<sup>8</sup> and notify issuers of any need for corrections. After the final QHP application submission deadline, issuers may be required to submit corrected final QHP data during a limited data correction window to address CMS or State-identified errors.

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<sup>5</sup> The list of States that do not enforce the ACA market wide-requirements is *available at*:

<https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/compliance.html>.

<sup>6</sup> 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 Final Letter.

<sup>7</sup> See Plan Year 2024 QHP Data Submission and Certification Timeline (March 10, 2023) *available at*: <https://www.cms.gov/files/document/py2024-qhp-data-submission-and-certification-timeline-bulletin.pdf>. All dates are subject to change.

<sup>8</sup> In accordance with 45 CFR Part 155 Subpart K, CMS will review, and approve or deny, QHP applications from issuers that are applying to offer QHPs in the FFEs. CMS will not conduct QHP certification reviews of plans that are submitted for offering only outside of the FFEs, except for SADPs seeking off-Exchange certification. In the case of an FF-SHOP QHP certification, except when the QHP is decertified pursuant to 45 CFR 155.1080, the QHP certification remains in effect through the end of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified. FFEs will not display ancillary insurance products and health plans that are not QHPs (e.g., stand-alone vision plans, disability, or life insurance products). The FFEs will only offer QHPs, including SADPs.

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.<sup>9</sup> 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 2024 QHP Data Submission and Certification Timeline, or if their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.<sup>10</sup>

## ***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 2024 QHP Data Submission and Certification Timeline and to make necessary updates to the QHP application before the last deadline for issuer submission. Additionally, issuers must comply with any CMS requirements related to rate filings. There are certain States where CMS is directly performing rate review as well as enforcing other applicable PHS Act requirements.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.<sup>11</sup> All issuers must also register for the PM Community to receive relevant

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<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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/ccio/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 the 2024 plan year that are the same as plans, including SADPs, certified as QHPs for the 2023 plan year, 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 that SADP issuers' HIOS plan identification numbers will be the same for the 2024 plan year if the plan has not changed since the SADP was certified for the 2023 plan year, even if the plan has been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value (AV). The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to 45 CFR 155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for the 2024 plan year that had been certified for the 2023 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

communications regarding their QHP applications.<sup>12</sup>

Issuers applying for QHP certification in FFEs, excluding those in States performing plan management functions, must submit their QHP applications in HIOS.<sup>13</sup> 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.<sup>14</sup>

All issuers applying for QHP certification for the 2024 plan year will receive feedback on whether their data passes validations at the point of submission as well as after the data are fully submitted to CMS. CMS encourages applicants to access the Plan Preview module of HIOS to review plan data, verify that their plan display reflects their State-approved filings, and identify and correct data errors before the QHP application data submission deadline. Issuers can use Plan Preview to check their plan benefit data display for most enrollment scenarios, including service areas, cost sharing for benefits, and URLs, including payment redirect.

CMS encourages issuers to review the data in Plan Preview throughout the QHP certification process to ensure that the plan benefit data are correct. Discrepancies between an issuer's QHP application and approved State filings may result in a plan not being certified. If CMS has already certified a plan as a QHP, the plan may be decertified or subject to appropriate compliance or enforcement action.

### ***Section 3. QHP Data Changes***

CMS will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to 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. CMS will monitor all data changes and contact issuers if there are concerns about changes made.

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<sup>12</sup> For issuers not currently participating in the PM Community, in spring 2023 CMS intends to make instructions available on how to enroll to receive information for the 2024 plan year QHP application period.

<sup>13</sup> 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.

<sup>14</sup> 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.

Table 1.1 Data Changes

	<b>Permitted with No State or CMS Authorization Required</b>	<b>Permitted with Authorization*</b>	<b>Not Permitted</b>
<b>Before the Initial Submission Deadline</b>	All data changes permitted.	N/A	N/A
<b>Between the Initial and Final Data Submission Deadlines</b>	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.
<b>After the Final Submission Deadline</b>	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. 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.<sup>15</sup> Issuer changes made in the limited data correction window not approved by CMS and/or the State may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After completion of the QHP certification process, CMS may offer additional data correction windows. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the State or CMS. CMS will offer windows for SHOP quarterly rate updates for issuers in an FF-SHOP. Issuers should make administrative data changes for QHP application submissions, such as URL updates, in HIOS and are not required to submit a data change request to CMS for such changes. URL changes require State authorization before being updated.

A request for a data change after the final submission deadline, excluding administrative changes or SHOP quarterly rate updates, may be made due to inaccuracies in or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved State filings may result in a plan not being certified or 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 reasonableness of rates and compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines.<sup>16</sup> States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.<sup>17</sup> Issuers in

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<sup>15</sup> See 45 CFR 156.805(a)(5).

<sup>16</sup> States are the primary regulators of health insurers and are responsible for enforcing the consumer protections and market reform provisions amended or extended by the Patient Protection and Affordable Care Act (ACA) and Consolidated Appropriations Act, 2021 (CAA), along with other federal requirements, in title XXVII of the PHS Act with respect to health insurance coverage offered both inside and outside the Exchanges. Under sections 2723 and 2761 of the PHS Act and regulations codified at 45 CFR Part 150, CMS is responsible for enforcing the provisions of Parts A, B, and D of title XXVII of the PHS Act with respect to health insurers in the individual and group markets when the State informs CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the applicable provisions, or if CMS determines that the State is not substantially enforcing one or more of the applicable provisions. As necessary, CMS will provide additional information on enforcement. CMS reviews form filings from issuers in Missouri, Oklahoma, Texas, and Wyoming (direct enforcement States) for compliance with the ACA market reform provisions and other applicable federal requirements in title XXVII of the PHS Act that CMS is responsible for enforcing. In addition, CMS is reviewing form filing submissions for compliance with certain CAA provisions from issuers in American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, Nevada, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Texas, Virginia, and Wyoming. CMS published letters to States that are not enforcing provisions of the PHS Act extended or added by the CAA available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA>. Issuers in these States and the direct enforcement States should work with CMS in instances in which this guidance references the "state," but should be aware that they will still generally continue to have some obligations under State law.

<sup>17</sup> See Center for Consumer Information and Insurance Oversight, CMS, Bulletin: Timing of Submission of Rate

States that do not review policy forms for compliance with federal requirements should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.<sup>18</sup>

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

CMS expects that States will establish the timeline, communication process, and resubmission window for any reviews conducted under State authority. As noted previously, issuers should comply with any State-specific guidelines for review and resubmission related to State review standards. CMS notes that issuers may be required to submit data to State regulators in addition to what is required for QHP certification through the FFEs, if required by a State, and must comply with any requests for resubmissions from the State or from CMS in order to be certified. CMS will seek to coordinate with States so that any State-specific review guidelines and procedures are 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 QHPs 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.<sup>20</sup> CMS understands that all State reviews might not be complete by the submission deadlines, but as stated above, CMS requires State confirmation of approval of QHPs for sale before CMS certification.

All States are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to State guidelines separate from ACA certification requirements, as early in the certification process as practicable. For CMS to ensure this information is accounted for during certification, States must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the

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Filing Justifications for the 2023 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2024 (March 10, 2023), available at: <https://www.cms.gov/files/document/2023-final-rate-review-bulletin.pdf>.

<sup>18</sup> 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>.

<sup>19</sup> States performing plan management functions in the FFEs will conduct certification reviews. In addition, all States with FFEs, regardless of whether they perform plan management functions, will conduct certification reviews for certain review areas, as detailed in Chapter 2.

<sup>20</sup> SBE-FPs should not transfer off-Exchange SADPs.

State plan confirmation deadline in the QHP Data Submission and Certification Timeline. CMS will provide States with detailed guidance regarding the process for submitting plan approval recommendations to CMS before the start of and throughout the QHP certification cycle. CMS will work with all State regulators to confirm by the State plan confirmation deadline that all potential QHPs meet applicable State and federal standards, and are approved for sale in the State.

### ***Section 5. Plan ID Crosswalk***

Issuers are required to submit plan ID crosswalk data for each medical QHP and SADP that was certified for the 2023 plan year. Please refer to the 2018 Letter to Issuers for more information regarding submission requirements pertinent to the Plan ID Crosswalk.

In the HHS Notice of Benefit and Payment Parameters for 2024 Final Rule (2024 Payment Notice),<sup>21</sup> CMS finalized a policy to allow the Exchange, beginning in the 2024 plan year, to direct re-enrollment for enrollees who are eligible for cost-sharing reductions (CSRs) in accordance with § 155.305(g) from a bronze QHP to a silver QHP with a lower or equivalent premium after advance premium tax credits (APTC) within the same product and with the same provider network as the bronze QHP into which they would otherwise have been re-enrolled, regardless of whether their current plan is available or not, if certain conditions are met (referred to here as the “bronze to silver crosswalk policy”). This policy applies only to the extent permitted by applicable State law, and does not apply if the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP.

CMS also finalized amendments to the Exchange re-enrollment hierarchy to require all Exchanges (Exchanges on the Federal platform and SBEs) to take into account network similarity to the current year plan when auto re-enrolling enrollees whose QHPs are no longer available to them.

CMS also clarified in the 2024 Payment Notice that Exchanges implementing the bronze to silver crosswalk policy will compare net monthly silver plan premiums for the coming year with net monthly premiums for bronze plans for the coming year, as opposed to net monthly bronze plan premiums for the current year (where net premium is the enrollee’s responsible amount after applying APTC). This clarification ensures that Exchanges will make auto re-enrollment determinations based on comparable premium information.

Finally, the 2024 Payment Notice clarified that State regulatory authorities and Exchanges have the option to apply the bronze to silver crosswalk policy to the approach that they use for cross-issuer enrollments, sometimes referred to as alternate enrollments. Specifically, in Exchanges on the Federal platform, when an applicable State regulator defers to the Exchange, CMS will crosswalk enrollees in a bronze plan who are eligible for CSR, and who would otherwise be auto re-enrolled in a bronze plan, to a silver level QHP within the same product, with the same provider network, and with a lower or equivalent net premium as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee based on the applicable section of the 2023 Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health

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<sup>21</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024; Final Rule (April 27, 2023), 88 FR 25740, available at <https://www.govinfo.gov/content/pkg/FR-2023-04-27/pdf/2023-08368.pdf>.

Options Program (FF-SHOP) Enrollment Manual.

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 2023 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for SADPs offered during the 2024 plan year.

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

The approach for 2024 remains unchanged from 2021, 2022, and 2023. Please refer to the 2021 Letter to Issuers for more information.

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

The approach for 2024 remains unchanged from 2022 and 2023. Please refer to the 2022 Letter to Issuers for more information and for some possible pathways for adoption of these approaches.

### ***Section 8. Issuer Participation for the Full Plan Year***

The approach for 2024 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

### ***Section 9. Standardized Plan Options***

The approach to standardized plan options for 2024 remains in large part unchanged from the approach in 2023. Please refer to the 2023 Letter to Issuers for a summary of these requirements.

That said, there are several minor differences between the approaches for 2024 and 2023. First, consistent with the proposed approach in the 2024 Payment Notice proposed rule, in the 2024 Payment Notice final rule, CMS did not finalize standardized plan options for the non-expanded bronze metal level for the 2024 plan year. Second, CMS finalized several minor updates to the plan designs to ensure these standardized plan options have actuarial values (AVs) within the permissible AV *de minimis* range for each metal level. Refer to the preamble for 45 CFR 156.201 in the 2024 Payment Notice for these plan designs. Finally, CMS made several minor updates to the standard silver metal level standardized plan options in both sets of plan designs, specifically by decreasing the deductibles by \$100 from \$6,000 to \$5,900, which increased the AV from 70.00% to 70.01% due to an error in our use of the proposed AV Calculator and Plans and Benefits Template. These changes also apply to the final AV Calculator and Plans and Benefits Template. All other aspects of plan design remain unchanged from the proposed rule.

Regarding prescription drug formulary tiering for these standardized plan options, for the 2024 plan year, in the 2024 Payment Notice, CMS finalized the specification that if an issuer includes the Zero Cost Share Preventive Drugs tier type in its standardized plan options, that tier type must be entered as tier one for the associated formulary ID within the Prescription Drug Template. Similarly, CMS finalized the specification that if an issuer includes the Medical Service Drugs tier type in its standardized plan options, that tier type must be entered as the highest tier for the associated formulary ID within the Prescription Drug Template. Finally, CMS finalized the specification that if an issuer includes both the Zero Cost Share Preventive Drugs

and the Medical Service Drugs tier types in their standardized plan options, then the Zero Cost Share Preventive Drugs tier type must be entered as tier one and the Medical Service Drugs tier type must be entered as final tier within the Prescription Drug Template.

Finally, in contrast with the proposed rule, CMS did not finalize the specification requiring issuers to place all offered generic drugs on the generic prescription drug cost sharing tier, or the specialty prescription drug cost sharing tier if there is an appropriate and non-discriminatory basis for doing so in standardized plan options. Similarly, CMS did not finalize the specification requiring issuers to place all offered brand drugs on either the preferred brand or non-preferred brand prescription drug cost sharing tiers, or the specialty prescription drug cost sharing tier if there is an appropriate and non-discriminatory basis for doing so in standardized plan options. As such, issuers will continue to retain the discretion to place particular prescription drugs on specific formulary tiers, subject to existing non-discrimination requirements.

### ***Section 10. Limits to the Number of Non-Standardized Plan Options***

CMS finalized at 45 CFR 156.202 of the 2024 Payment Notice, as a condition of QHP certification for the 2024 plan year, to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges on the Federal platform (including State-based Exchanges on the Federal Platform) to four non-standardized options per product network type (as described in the definition of “product” at 45 CFR 144.103) and metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area. For the 2025 plan year and beyond, the limit will be reduced from four to two.

Similar to the approach taken to standardized plan options in the HHS Notice of Benefit and Payment Parameters for 2023 Final Rule (2023 Payment Notice),<sup>22</sup> as well as the approach taken in the 2024 Payment Notice, CMS finalized its proposed approach to not apply this requirement to issuers in State Exchanges, to small group market issuers, or to SADPs.

In the 2024 Payment Notice, CMS clarified that, to distinguish a plan for purposes of whether it includes dental and/or vision benefit coverage, a non-standardized plan option must include any or all of the following adult dental benefit coverage in the “Benefits” column in the Plans and Benefits Template: 1) Routine Dental Services (Adult), 2) Basic Dental Care – Adult, or 3) Major Dental Care – Adult. CMS also clarified that a non-standardized plan option must include any or all of the following pediatric dental benefit coverage in the “Benefits” column in the Plans and Benefits Template: 1) Dental Check-Up for Children, 2) Basic Dental Care – Child, or 3) Major Dental Care – Child. Finally, CMS clarified that a non-standardized plan option must include either or both of the following adult and pediatric vision benefit coverage in the “Benefits” column in the Plans and Benefits Template: 1) Routine Eye Exam (Adult) or 2) Routine Eye Exam for Children.

In the 2024 Payment Notice, CMS clarified that the “service area” component in the limit on the number of non-standardized plan options is defined as Federal Information Processing Series (FIPS) code. A FIPS code is a five-digit code that is unique to every county in the country and provides a standardized, widely utilized, comprehensive, and mutually exclusive geographic unit

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<sup>22</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023; Final Rule (May 6, 2022), 87 CFR 27208, available at <https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf>.

for assessing consumer choice overload and adherence to non-standardized plan option limits.

Under this requirement, an issuer would, for example, be limited to offering four gold HMO and four gold PPO non-standardized plan options in that same service area in the 2024 plan year if that issuer did not include any of the specified dental and/or vision benefit coverage in those non-standardized plan options.

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

As a final clarifying example, if an issuer included any of the specified dental and/or vision benefit coverage in some of its non-standardized plan options, that issuer would, for example, be permitted to offer four non-standardized gold HMOs with no dental or vision benefit coverage, four non-standardized gold HMOs with dental benefit coverage, four non-standardized gold HMOs with vision benefit coverage, and four non-standardized gold HMOs with dental and vision benefit coverage, as well as four non-standardized gold PPOs with no dental or vision benefit coverage, four non-standardized gold PPOs with dental benefit coverage, four non-standardized gold PPOs with vision benefit coverage, and four non-standardized gold PPOs with dental and vision benefit coverage, in the same service area.

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

(This chapter relies on authority from ACA sections 1302, 1311(c) and (e), 1321(a), and 1402; PHS Act section 2794; and 45 CFR 146.130, 147.136, 147.138, Part 154, 155.1045, 155.1065, 156.115, 156.122, 156.125, 156.150, 156.200, 156.210, 156.221, 156.225, 156.230, 156.235, 156.410, 156.420, 156.425, 156.1105-1130, and 156.1250.)

This chapter provides an overview of key QHP certification standards for 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 2024 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 Exchanges for Plan Years 2018 and Later (“State Guidance on QHP Reviews”) for more information.<sup>23</sup> As noted in the State Guidance on QHP Reviews, CMS

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<sup>23</sup> See Center for Consumer Information and Insurance Oversight, CMS, Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Exchanges for Plan Years 2018 and Later (Apr. 13, 2017), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certification-Reviews-Guidance-41317.pdf>.

does not review issuers' compliance with licensure and good standing standards. In FFEs, including in States performing plan management functions, States will continue to ensure issuer compliance with 45 CFR 156.200(b)(4).

## ***Section 2. Service Area***

The approach for reviews of service area remains unchanged from 2023. Issuers may make changes to their plan's service area after the initial submission deadline without first submitting a data change request for CMS authorization. After the final submission deadline listed in the Plan Year 2024 QHP Data Submission and Certification Timeline,<sup>24</sup> a data change request is required for any change to QHP data, including service area.

## ***Section 3. Network Adequacy***

This section describes how CMS will conduct reviews of the network adequacy standards for medical QHP and SADP certification for the 2024 plan year. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

For the 2024 plan year, CMS will evaluate QHPs for compliance with network adequacy standards based on time and distance standards but, as reflected in the 2024 Payment Notice, will delay applicability of the appointment wait time standards until the 2025 plan year. CMS will continue collecting from QHPs information on whether providers participating in their network offer telehealth services to inform future policy decision making. Finally, CMS will continue coordinating closely with State authorities to address network adequacy compliance issues, eliminate duplicative requirements or reviews, and reduce stakeholder burden.

### **i. Requirement to use a provider network**

As announced in the 2024 Payment Notice, CMS revised the network adequacy and essential community providers (ECP) standards at 45 CFR 156.230 and 45 CFR 156.235 to state that all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchange-types must use a network of providers that complies with the standards described in those sections, and to remove the exception at 45 CFR 156.230(f) that these sections do not apply to plans that do not use a provider network, beginning with the 2024 plan year. As finalized, an Exchange cannot certify as a QHP a health plan that does not use a network of providers that complies with the network adequacy standards. This revision assures HHS that the QHP certification criteria relevant to the availability of providers conforms to the minimum QHP certification criteria, including those described at section 1311(c)(1)(B) and (C) of the ACA.

Additionally, CMS finalized in the 2024 Payment Notice a limited exception to the provider network requirement for SADP issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception is not applicable to medical QHP issuers at this time. Under this exception, we will consider an area to be "prohibitively difficult" for the SADP issuer to establish a network of dental providers based on attestations from State departments of insurance with at least 80 percent of their counties

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<sup>24</sup> See *supra* note 7.

classified as Counties with Extreme Access Considerations (CEAC)<sup>25</sup> that at least one of the following factors exists in the area of concern:

- Significant shortage of dental providers.
- Significant number of dental providers unwilling to contract with Marketplace issuers.
- Significant geographic limitations impacting consumer access to dental providers.

We expect that States, in determining whether an area has been impacted by at least one of the above factors to the degree of being considered “prohibitively difficult” for SADP issuers to establish a network of dental providers, will take into account a number of factors, such as the availability of other SADPs that use a provider network in the service area and prior years’ network adequacy data to identify counties in which SADP issuers have struggled to meet standards due to a shortage of dental providers. Other factors could include extreme difficulties in developing a dental provider network, data provided in the ECP/NA template or justification forms during the QHP application submission process that reflect such extreme difficulties, and geographic barriers.

## **ii. FFE Network Adequacy Reviews**

The approach for FFE network adequacy time and distance reviews remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

## **iii. Network Adequacy for QHP Issuers in FFEs**

### *a. Time and Distance Standards*

The approach for time and distance standards remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

### *b. Appointment Wait Times*

In the 2024 Payment Notice, CMS delayed applicability of the appointment wait time standards until the 2025 plan year. Accordingly, QHP issuers in FFEs will have one additional plan year before being required to attest to meeting appointment wait time standards.

As we noted in the 2023 Payment Notice, specific guidelines for complying with appointment wait time standards will be released in later guidance. This will allow HHS additional time to develop specific guidelines for how issuers should collect the requisite data from providers, how the metrics should be interpreted, and for public comment on the proposed guidance. Issuers that do not yet meet the appointment wait time standards, once implemented in the 2025 plan year, will be able to use the justification process to update HHS on the progress of their contracting efforts for the respective plan year.

We encourage issuers that have implemented monitoring and data collection of provider appointment wait times to continue to do so. However, under this new timeline, we will not be

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<sup>25</sup> At least 80 percent of the counties in the respective State must be classified by CMS to be Counties with Extreme Access Considerations (CEAC), based on US Census Bureau population density estimate of fewer than 10 people per square mile.



actively collecting or requiring submission of any data or attestations for compliance with the standards for purposes of QHP certification for the 2024 plan year.

#### **iv. Network Adequacy Justification Process**

As for the 2023 plan year, if an issuer's application does not satisfy the network adequacy standard, an issuer is required to include a satisfactory justification as part of its application for QHP certification. The justification process remains unchanged from the 2023 plan year. CMS will accept only the official Network Adequacy Justification Form, which is a partially prepopulated Excel document. CMS will review any updated provider data submitted on the issuer's ECP/NA template and completed Network Adequacy Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, before making the certification decision. CMS will continue to monitor network adequacy throughout the year and will coordinate with State Departments of Insurance should it be necessary to remedy potential corrections and/or consider the extent to which any barriers beyond the issuer's control might be impeding an issuer's ability to satisfy the network adequacy standards.

CMS reminds issuers that an issuer choosing to enter into an exclusivity contract with a provider is not a sufficient justification to allow that issuer to fail to satisfy the network adequacy standards. However, if a provider has entered into an exclusivity contract with another issuer, CMS recognizes that competing issuers will be unable to contract with that provider. Similarly, CMS recognizes the potential impact of provider supply shortages and topographic barriers on an issuer's ability to satisfy the network adequacy standards. If an issuer encounters any such barriers directly impacting the issuer's ability to satisfy the network adequacy requirements, the issuer should document the nature and extent of the barrier within their Network Adequacy Justification using the official partially prepopulated form. This will ensure that CMS is aware of the potential barrier(s) so that CMS can more accurately assess the issuer's satisfaction of the network adequacy standard once CMS confirms the nature and extent of the barrier. In the meantime, CMS expects such issuers to demonstrate to CMS via their Network Adequacy Justification how they are continuing to monitor their service area throughout the year for new providers that may enter their service area for the purpose of offering them a contract to help fill any network adequacy gaps identified by CMS.

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

#### **v. Telehealth Services**

The approach for telehealth services remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

#### **vi. Network Transparency**

The approach for network transparency remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

## ***Section 4. Essential Community Providers***

At 45 CFR 156.235, CMS established QHP issuer requirements for inclusion of ECPs in provider networks, which requires that issuers include at least a certain threshold 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 ECP standard for the 2024 plan year and the approach for reviews of the ECP standard, as stated in the 2024 Payment Notice, remains the same as for the 2023 plan year, with the exception of the changes noted below. Please refer to the 2018 Letter to Issuers for full details.

### **i. Requirement to use a provider network**

As described in section 3 of this chapter, CMS announced in the 2024 Payment Notice that it revised the network adequacy and ECP standards at 45 CFR 156.230 and 45 CFR 156.235 to state that all individual market QHPs, including individual market SADPs, and all SHOP QHPs, including SHOP SADPs, across all Exchange-types must use a network of providers that complies with the standards described in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network, beginning with the 2024 plan year. As finalized, an Exchange cannot certify as a QHP a health plan that does not use a network of providers that complies with the ECP standards. Please refer to section 3 of this chapter for details regarding this provider network requirement and the limited exception for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

### **ii. Addition of two new major ECP categories**

In the 2024 Payment Notice, CMS finalized the ECP categories, as follows:

- Replaced the “Community Mental Health Centers” provider type, previously included in the “Other ECP Providers” category with specific qualifying provider types enumerated at 45 CFR 156.235(a)(2)(ii)(B), with a separate, newly established “Mental Health Facilities” ECP category.
- Replaced the “SUD Treatment Centers” provider type, previously included in the “Other ECP Providers” category, into the newly established “Substance Use Disorder Treatment Centers” ECP category.
- Added Rural Emergency Hospitals as a provider type in the “Other ECP Providers” ECP category. This addition reflects the fact that on or after January 1, 2023, REHs may begin participating in the Medicare program.

The eight (8) stand-alone ECP categories and their associated provider types consist of:

Table 2.1: ECP Categories and Provider Types in FFEs for the 2024 Plan Year and beyond

<b>Major ECP category</b>	<b>ECP provider types</b>
Federally Qualified Health Centers (FQHC)	FQHC and FQHC “Look-Alike” Clinics
Ryan White Program Providers	Ryan White HIV/AIDS Providers

Major ECP category	ECP provider types
Family Planning Providers	State-owned family planning service sites, Governmental family planning service sites, including Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics, Not-for-profit family planning service sites that do not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding
Indian Health Care Providers	Tribes, Tribal Organization and Urban Indian Organization Providers, Indian Health Service Facilities
Inpatient Hospitals	Disproportionate Share Hospital (DSH), Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Substance Use Disorder Treatment Centers	Substance Use Disorder Treatment Providers
Mental Health Facilities	Community Mental Health Centers, Other Mental Health Providers
Other ECP Providers	Black Lung Clinics, Hemophilia Treatment Centers, Rural Health Clinics, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Rural Emergency Hospitals

QHP issuers must offer a contract in good faith to at least one ECP in each of the available eight ECP categories in each county in the plan’s service area, including the two newly created stand-alone categories of Mental Health Facilities and Substance Use Disorder Treatment Centers.<sup>26</sup> The previously existing provider type of Community Mental Health Centers is now part of the newly created, stand-alone Mental Health Facilities ECP category on the HHS ECP list. The inclusion of substance use disorder treatment centers and mental health facilities on the HHS ECP List is limited to those facilities identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or CMS as providing such services, in addition to fulfilling other ECP qualification requirements as specified at 45 CFR 156.235(c).

**iii. Application of 35 percent ECP threshold to two major ECP categories, in addition to the overall 35 percent threshold**

For the 2024 plan year, the provider participation threshold remains at 35 percent of available ECPs in the plan’s service area, including approved ECP write-ins, which also count toward the issuer’s satisfaction of the 35 percent threshold. In the 2024 Payment Notice, in addition to this overall 35 percent threshold, CMS also applied the 35 percent threshold to two (2) of the major ECP categories: Federally Qualified Health Centers (FQHCs) and Family Planning Providers.

<sup>26</sup> Pursuant to 45 CFR 156.235(a)(2)(ii)(A), QHP issuers must offer a contract to all available Indian health care providers in the service area, rather than to only one Indian health care provider in each county in the plan’s service area.

This requirement requires medical QHP issuers to contract with at least 35 percent of FQHCs and at least 35 percent of Family Planning Providers in the plan's service area. SADP issuers are required to contract with at least 35 percent of FQHCs offering dental services in the plan's service area. For both medical QHPs and SADPs, these contracts also count toward the separate overall 35 percent threshold, which remains in place. This requirement applies to issuers submitting their QHP application under the General or Alternate ECP Standard, as described under 45 CFR 156.235(a)(2)(i) and (b)(2)(i), respectively.

Based on data from the 2023 plan year, it is likely that a majority of issuers will be able to meet or exceed the threshold requirements for FQHCs and Family Planning Providers without needing to contract with additional providers in these categories. To illustrate, if these requirements had been in place for the 2023 plan year, out of 137 QHP issuers on the FFE, 76 percent would have been able to meet or exceed the 35 percent FQHC threshold, while 61 percent would have been able to meet or exceed the 35 percent Family Planning Provider threshold without contracting with additional providers. For SADP issuers, 84 percent would have been able to meet the 35 percent threshold requirement for FQHCs offering dental services without contracting with additional providers.

In the 2023 plan year, for medical QHPs, the mean and median ECP scores for the FQHC category were 74 and 83 percent, respectively. For the Family Planning Providers category, the mean and median ECP scores were 66 and 71 percent, respectively. For SADPs, the mean and median ECP scores for the FQHC category were 61 and 64 percent, respectively.

#### **iv. ECP Justification Process**

As described in the 2018 Letters to Issuers, HHS prepares the applicable plan year HHS ECP list that potential QHPs use to identify eligible ECP facilities. If an issuer's application does not satisfy the ECP standard, an issuer is required to include a satisfactory justification as part of its application for QHP certification. The justification process remains unchanged from the 2023 plan year. As for the 2023 plan year, CMS will accept only the official ECP Justification Form, which is a partially prepopulated Excel document.

CMS reminds issuers that the decision to enter into an exclusivity contract with a provider is not a sufficient justification to allow an issuer to fail to satisfy the ECP standards. However, if a provider that appears on the HHS ECP List has entered into an exclusivity contract with another issuer, CMS recognizes that competing issuers will be unable to contract with that provider. Such exclusivity contracts disqualify the provider from inclusion on the HHS ECP List and will result in the provider's removal from the list to ensure that other issuers will not be penalized for failing to contract with the provider. As a result of the provider's disqualification from the HHS ECP List, the provider also will not be counted toward meeting the ECP threshold for the issuer with which it has the exclusive contract.

CMS may also remove a provider from the HHS ECP List after release of the respective plan year's final ECP List for reasons including facility closure, discontinuance of dental services (such that the provider can no longer participate in the provider network of an SADP), loss of ECP status (e.g., termination of 340B status or Health Professional Shortage Area designation, etc.), or demonstrated lack of interest in contracting with any Exchange issuers. While CMS conducts outreach to providers year-round to ensure their continued ECP status and interest in contracting with Exchange issuers, if an issuer encounters any such barriers to contracting with

providers that appear on the HHS ECP List, the issuer should document the nature and extent of the barrier within their ECP Justification using the official partially prepopulated form. This will ensure that CMS is aware of the provider's possible change in circumstance so that CMS can more accurately assess the issuer's satisfaction of the ECP standard once CMS confirms the respective provider's change in circumstance directly with either the provider or the designating entity (e.g., the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, Indian Health Service), as appropriate.

Finally, when a provider has failed to respond to an issuer's outreach attempt, the issuer should document such an outcome in their ECP Justification as the provider failing to respond and then reach out to another available provider within the same ECP category within the plan's service area in order to offer a contract in satisfaction of the requirement that the issuer offer a contract to at least one ECP in each ECP category in each county within the plan's service area. In other words, the requirement to offer contracts to at least one ECP in each category in each county in the service area can only be fulfilled by making actual contract offers. Provider outreach attempts alone are insufficient.

### ***Section 5. Accreditation***

The approach for reviews of the accreditation standard remains largely unchanged from 2020. HHS continues to encourage issuers to provide their accrediting entity (AE) the HIOS ID number associated with their organization as they begin to work with the AE(s) on accreditation.

### ***Section 6. Patient Safety Standards for QHP Issuers***

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

### ***Section 7. Quality Reporting***

The approach for QHP certification reviews of QHP issuer compliance with quality reporting standards related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey) remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information, and to the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023<sup>27</sup> for more detailed information on issuer data collection and reporting requirements for the 2023 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.

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<sup>27</sup> See Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023 (September 2022), available at: <https://www.cms.gov/files/document/2023-qrs-qhp-enrollee-survey-technical-guidance.pdf>.

## ***Section 8. Quality Improvement Strategy***

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2024 plan year.

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

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

The approach for reviewing rate filings for the 2024 plan year remains unchanged from the 2020 Letter to Issuers. Please refer to the 2020 Letter to Issuers and the Unified Rate Review Instructions for more information.<sup>28</sup>

Issuers in States with an Effective Rate Review Program that use SERFF are now able to comply with the requirement to submit rate filing justifications to CMS by submitting the rate filing directly in SERFF. New functionality is available beginning with the 2023 plan year, such that a rate filing filed in SERFF is automatically uploaded to the Uniform Rate Review (URR) Module of HIOS and will be considered filed with CMS once submitted in SERFF.<sup>29</sup> This new functionality does not apply to States that do not have an Effective Rate Review Program<sup>30</sup> and States that do not participate in SERFF. Issuers in those States will need to continue to submit the URR template directly in HIOS. These same guidelines apply to issuers in States that do not perform plan management functions and otherwise submit QHP application data in HIOS.

CMS will rely on States' reviews of issuer-submitted policy forms for market-wide standards as part of its QHP certification process, provided that States review for reasonableness of rates and compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines. Issuers in States that do not review policy forms for federal compliance should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.<sup>31</sup> These issuers will have to submit two sets of the same policy form filings. One filing will be submitted to the State through the State instance of SERFF and the second filing will be submitted to CMS through the CMS instance of SERFF.<sup>32</sup>

## ***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

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<sup>28</sup> See, e.g., the 2023 Unified Rate Review Instructions, available at: <https://www.cms.gov/files/document/urr-py23-instructions.pdf>.

<sup>29</sup> For additional details and operational guidance on submission of the URR template to CMS through SERFF, see the 2023 Unified Rate Review Instructions, available at: <https://www.cms.gov/files/document/urr-py23-instructions.pdf>.

<sup>30</sup> CMS will be responsible for reviewing the 2024 plan year rate filings in two States that do not have an Effective Rate Review Program (Oklahoma and Wyoming).

<sup>31</sup> See *supra* note 18.

<sup>32</sup> The database utilized by SERFF is divided into subsections called "instances." Every form filing belongs to one State instance and one industry instance. See the 2021 SERFF Complete State Manual, page 12, available at: <https://www.serff.com/> via "Profile," "Help," "User Manual."

benefit design and QHP discriminatory benefit design. The 2023 Payment Notice refined the essential health benefits (EHB) nondiscrimination policy for health plan designs. 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. 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***

For the 2024 plan year, CMS will begin conducting an adverse tiering review, in addition to the existing prescription drug reviews. The adverse tiering review will check that QHPs cover sufficient drugs or drug classes prescribed to treat chronic, and high-cost medical conditions at lower cost tiers. For the 2024 plan year, CMS will include the following medical conditions in the adverse tiering review: hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis. Drugs and drug classes in each condition under review are FDA approved drug therapies, as recommended by nationally recognized clinical guidelines.

### ***Section 12. Third Party Payment of Premiums and Cost Sharing***

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

### ***Section 13. Cost-sharing Reduction Plan Variations***

CMS will conduct Cost-sharing Reduction Plan Variations review of QHP Application templates as done in previous plan years. Eligible consumers can enroll in these plan variations for the 2024 plan year and will continue to receive CSRs provided by issuers. Since October 2017, CMS has not made CSR payments to issuers and cannot make CSR payments unless Congress appropriates funds for these payments.

### ***Section 14. Data Integrity Review***

CMS will conduct data integrity reviews of QHP Application templates as done in previous plan years. The review will identify data errors that would result in improper display of plan information to consumers as well as other template irregularities.

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

In the 2024 Payment Notice, CMS finalized a requirement that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading.<sup>33</sup> Starting in the 2024 plan year, CMS will review plan and

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<sup>33</sup> In practice, CMS and stakeholders often use the term “plan variants” to refer to “plan variations.” Per 45 CFR § 156.400, plan variation means a zero-cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation. Issuers may choose to vary plan marketing name by the plan variant – for example, use one plan marketing name for a silver plan that meets the AV requirements at 45 CFR 156.140(b)(2), and a different name for that plan’s equivalent that meets the AV requirements at 45 CFR 156.420(a)(1), (2), or (3).

plan variation marketing names for misleading information, inaccurate information, or omission of material fact during the annual QHP certification process.

### **Plan Marketing Name Guidance**

All information included in plan and plan variation marketing names that refers to cost sharing and/or other benefit information should correspond to benefit information in other plan documents, including the Plans & Benefits Template, *HealthCare.gov* plan selection information, and other applicable QHP certification materials. Consumers applying for coverage should be able to understand references to benefit information in plan marketing names, and they should be able to confirm any information from a plan marketing name in the plan's publicly-available benefit descriptions and policy documents.

Examples of information that should be validated to ensure accuracy and consistency across the plan or plan variation marketing name, Plans & Benefits Template, *HealthCare.gov* plan selection information, and other applicable QHP certification materials:

- Deductible amounts
- For tiered or network-specific benefits, which tier or network is referenced
- Maximum out of pocket (MOOP) amounts
- Benefit copay or coinsurance
- Initial free or discounted visits
- Ability of the plan to be paired with a health savings account (HSA)<sup>34</sup>

### ***Section 16. Interoperability***

The Interoperability and Patient Access Final Rule<sup>35</sup> was finalized on May 1, 2020. For the 2024 plan year, the policy remains unchanged from the 2022 plan year. 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. 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.

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<sup>34</sup> An HSA is a tax-exempt trust or custodial account that a taxpayer may set up with a qualified HSA trustee to pay or reimburse certain medical expenses the taxpayer incurs. (See IRS Publication 969 (2021), Health Savings Accounts and Other Tax-Favored Health Plans: [https://www.irs.gov/publications/p969#en\\_US\\_2021\\_publink1000204030](https://www.irs.gov/publications/p969#en_US_2021_publink1000204030).) Taxpayers must meet certain requirements to qualify for an HSA, including being enrolled in a High Deductible Health Plan (HDHP) as defined in section 223(c)(2) of the Internal Revenue Code. HDHP requirements include minimum levels for family and individual deductible amounts – for example, for calendar year 2022, an HDHP was defined as a health plan with an annual deductible not less than \$1,400 for self-only coverage or \$2,800 for family coverage, with annual out-of-pocket expenses not more than \$7,050 for self-only coverage or \$14,100 for family coverage. (See IRS Rev. Proc. 2021-25: <https://www.irs.gov/pub/irs-drop/rp-21-25.pdf>; updated in 2023 to \$1,500, \$3,000, \$7,500, and \$15,000, respectively, per [irs.gov/pub/irs-drop/rp-22-24.pdf](https://www.irs.gov/pub/irs-drop/rp-22-24.pdf).) Plan variants with limited or no cost sharing, such as those described at 45 CFR 156.420(a)(1) and (b)(1), by definition do not meet the requirements to be HDHPs, and enrollees in these plans therefore cannot contribute to an HSA. CMS will consider references to HSAs in the names of plans that do not qualify as HDHPs to be incorrect and misleading.

<sup>35</sup> 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 FR 25,510 (May 1, 2020), available at: <https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf>.



As noted in the Notification of Enforcement Discretion released on December 10, 2021,<sup>36</sup> 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 the 2024 plan year. QHP issuers are encouraged to review the Federal Register notice referenced above announcing enforcement discretion for more information.<sup>37</sup>

## **CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION**

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

### ***Section 1. Consumer Support Tools***

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

### ***Section 2. Transparency in Coverage Reporting***

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

Pursuant to 45 CFR 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection request, CMS-10572, “Transparency in Coverage Reporting by Qualified Health Plan Issuers,” under the Paperwork Reduction Act (PRA) to OMB for an additional 3-year collection period. This updated information collection request was approved on April 12, 2022, and will cover collections for the 2024 and 2025 plan years. Starting in the 2024 plan year, the data collection elements that QHP issuers reported from 2020 to 2023 will remain part of this collection, and issuers will also be required to respond to additional items assessing in- and out-of-network claims outcomes at the issuer level, and reasons for claims denials at the plan level. Transparency in Coverage URL submissions should be made in HIOS at the time of QHP application submission.

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<sup>36</sup> 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>.

<sup>37</sup> Note that CMS recently published a notice of proposed rulemaking on Advancing Interoperability and Improving Prior Authorization Processes, available at: <https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf>. A more detailed summary of these proposals, which have a proposed compliance date of 2026, can be found here: <https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact>.”

### ***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: 2024 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 2023, with the exception of additional standards that would be effective beginning in the 2024 plan year if finalized as proposed, as described in Sections 3 and 4 below. Please refer to the 2018 and 2023 Letters to Issuers for more information.

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

For the 2024 plan year, the SADP annual limitation on cost sharing for one covered child is \$350 increased by the 15.336 percentage point increase in the Consumer Price Index (CPI) for dental services of 528.630 for 2022 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by \$53.68 to a total of \$403.68. The regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of \$25, meaning the annual limitation on cost sharing for SADPs for the 2024 plan year will be \$400 for one child and \$800 for two or more children. For more information on how this limitation is determined, please refer to 45 CFR 156.150 and to the 2018 Letter to Issuers.

### ***Section 2. SADP Actuarial Value (AV) Requirements***

The approach to AV requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021. Please refer to the 2021 Letter to Issuers for more information. For the 2024 plan year, SADP issuers may offer the pediatric dental EHB at any AV. SADP issuers will be required to certify the AV of each SADP's coverage of pediatric dental EHB.

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

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

In the 2024 Payment Notice, CMS finalized the provision at new 45 CFR 156.210(d)(1) to require SADP issuers, as a condition of Exchange certification, to use an enrollee's age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee's age for rating and eligibility purposes, beginning with Exchange

certification for the 2024 plan year. CMS finalized that this requirement applies to all Exchange-certified SADPs, whether they are sold on- or off-Exchange.

As stated in the 2024 Payment Notice, requiring SADP issuers to use the age on effective date methodology for calculating an enrollee's age, and consequently removing the less commonly used and more complex age calculation methods, CMS believes this change will reduce consumer confusion and promote operational efficiency.

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

In the 2024 Payment Notice, CMS finalized the provision at new 45 CFR 156.210(d)(2) to require SADP issuers, as a condition of Exchange certification, to submit guaranteed rates beginning with Exchange certification for the 2024 plan year. CMS finalized that this requirement applies to all Exchange-certified SADPs, whether they are sold on- or off-Exchange.

As stated in the 2024 Payment Notice, CMS believes this change will help reduce the risk of incorrect APTC calculation for the pediatric dental EHB portion of premiums, thereby reducing the risk of consumer harm.

### **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.

#### ***Section 1. Provide Issuers Information Regarding the Registration Completion List and Health Line of Authority Check***

Pursuant to 45 CFR 156.340, a QHP issuer participating in the FFEs, including FFEs where States perform plan management functions,<sup>38</sup> maintains responsibility for ensuring that its delegated and downstream entities, including affiliated agents and brokers, comply with applicable laws and regulations.<sup>39</sup> Accordingly, QHP issuers must confirm all affiliated agents' and brokers' licensure statuses, and verify fulfillment of the applicable FFE registration and training requirements before allowing access to the QHP issuers' tools to assist with enrollment through the FFEs and/or providing compensation<sup>40</sup> for active Exchange transactions. QHP issuers in the FFEs, including FFEs where States perform plan management functions, must

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<sup>38</sup> Agents and brokers assisting Exchange consumers in an SBE-FP must also complete applicable FFE registration and training requirements. See 45 CFR 155.220(a)(1).

<sup>39</sup> QHP issuers participating in SBE-FPs also maintain responsibility for ensuring their delegated and downstream entities, including affiliated agents and brokers, comply with applicable laws and regulations. See 45 CFR 156.340(a)(2).

<sup>40</sup> Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker. See, e.g., Frequently Asked Questions on Agent/Broker Compensation and Guaranteed Availability of Coverage, (June 7, 2022), *available at*: <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf>.

verify agents' and brokers' FFE registration and training status for each plan year by visiting the CMS agent and broker resources page and linking to the Registration Status Lists (Registration Completion List (RCL) and Registration Termination List (RTL)) on [data.HealthCare.gov](https://data.healthcare.gov).<sup>41</sup>

For the current plan year, the agent and broker FFE RCL has an NPN Validation column. The indicator in the NPN Validation column reflects the check CMS performs against the National Insurance Producer Registry (NIPR <https://www.nipr.com>) database. A valid National Producer Number (NPN) and an active licensure status in a health-related line of authority (<https://data.healthcare.gov/AB-NIPR-Health-Line-Of-Authority>) are required in the resident State for display of a "Yes" in this column.

CMS intends to continue to work with States as well as issuers to monitor the activities of agents and brokers participating in the Exchanges that rely on the Federal Platform, and prevent fraud, waste, and abuse.

## **CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES**

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

### ***Section 1. Coverage Appeals***

The approach to coverage appeals generally remains unchanged. Please refer to the 2023 Letter to Issuers for more information.

Under 45 CFR 147.136(d)(4), insured coverage in States that do not have an applicable State external review process, including with regard to compliance with the expanded scope of external reviews to include surprise billing and cost-sharing protections under sections 2799A-1 or 2799A-2 of the PHS Act (No Surprises Act (NSA) compliance matters), may satisfy the requirement to provide for external review of adverse determinations by electing to use the Federal HHS-administered external review process.

Alternatively, plans and issuers subject to an applicable State external review process that cannot accommodate external review of NSA compliance matters may choose to use the accredited independent review organization (IRO) contracting Federal External Review process for NSA compliance matters only (45 CFR 147.136(d)(1)-(3)).

Plans and issuers may contact their respective departments of insurance for additional guidance regarding their State's ability to accommodate external review requests for NSA compliance matters. More information is available in Guidance for States, Plans, and Issuers on State

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<sup>41</sup> See FFM Agent Broker Registration Status Lists *available at*: [https://data.healthcare.gov/ffm\\_ab\\_registration\\_lists](https://data.healthcare.gov/ffm_ab_registration_lists). See RCL and RTL data dictionaries *available at*: <https://data.healthcare.gov/AB-NIPR-Health-Line-Of-Authority> and [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/62416-AB-Registration-Completion-List-Data-Dictionary-Web\\_v1.pdf](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/62416-AB-Registration-Completion-List-Data-Dictionary-Web_v1.pdf). QHP issuers participating in the FFEs, including Exchanges where States perform plan management functions, as well as the SBE-FPs may use the "expiration date" on the RCL, or the Registration Termination List, to check for suspension or termination (voluntary or for cause) of an agent's or broker's registration status for a particular plan year.

External Review Processes Regarding Requirements in the No Surprises Act.<sup>42</sup>

### ***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 proficiency (LEP) speakers and individuals with disabilities.

The approach to meaningful access generally remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information.

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

The guidance on the SBC generally remains unchanged. To clarify, the sample completed SBC templates are a reference tool. Plans and issuers are not required to reproduce the samples exactly as shown, except when form language and formatting must be precisely reproduced, as indicated in the Group and Individual instructions. SBCs that plans and issuers prepare for individuals must reflect as accurately as possible the benefits under that plan or policy, consistent with the instructions. With advice and input received through tribal consultation, CMS released sample completed SBCs for an AI/AN limited cost-sharing plan and an AI/AN zero cost-sharing plan in 2016. As with the other SBC documents, these documents are posted to the CMS website and can be used as a resource for issuers to develop SBCs for AI/AN consumers in zero cost-sharing<sup>43</sup> or limited cost-sharing plans.<sup>44</sup> We remind issuers of the requirement that the Limited Cost-sharing plan variation SBCs use the phrase “Cost sharing waived at non-IHCP with IHCP referral” in the limitations, exceptions, & other important information section.

## **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.<sup>45</sup>

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<sup>42</sup> The Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the No Surprises Act is available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NSA-Guidance.pdf>.

<sup>43</sup> Sample AI/AN Zero Cost sharing available: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AIAN-Zero-Cost-Sharing-01-2020.pdf>

<sup>44</sup> Sample AI/AN Limited Cost-sharing (PDF) available: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AIAN-Limited-Cost-Sharing-01-2020.pdf>

<sup>45</sup> The model QHP Addendum for Indian health providers is available at: [https://www.qhpcertification.cms.gov/s/Model\\_QHP\\_Addendum\\_Indian\\_Health\\_Care\\_Providers.pdf?v=1](https://www.qhpcertification.cms.gov/s/Model_QHP_Addendum_Indian_Health_Care_Providers.pdf?v=1).