DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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From: Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Title: 2027 Draft Letter to Issuers in the Federally-facilitated Exchanges

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2027 Draft Letter to Issuers in the Federally-facilitated Exchanges (2027 Draft Letter). This 2027 Draft Letter provides updates on operational and technical guidance for the 2027 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFEs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of this 2027 Draft Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2027. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2027 Draft Letter focuses on guidance that has been updated for the 2027 plan year, and refers issuers to the 2017 through 2026 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.[1] CMS notes that the policies articulated in

[1] *See* Center for Consumer Information and Insurance Oversight, CMS, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers_022916.pdf; Center for Consumer Information and Insurance Oversight, CMS, Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 17, 2017), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf; Center for Consumer Information and Insurance Oversight, CMS, 2019 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 9, 2018), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf; Center for Consumer Information and Insurance Oversight, CMS, 2020 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 18, 2019), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2021 Letter to Issuers in the Federally-facilitated Marketplaces (May 7, 2020), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2022 Letter to Issuers in the Federally-facilitated Marketplaces (May 6, 2021), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2023 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 28, 2022), *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf;

this 2027 Draft Letter apply to the QHP certification process for plan years beginning in 2027.[2] Throughout this 2027 Draft Letter, CMS identifies the areas in which States performing plan management functions in the FFEs have flexibility to follow an approach different from that articulated in this 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 2027 Draft Letter are to Title 45 of the CFR.[3] While certain parts of the 2027 Draft Letter explain associated regulatory requirements, the 2027 Draft Letter is not a complete list of regulatory requirements for issuers.

CMS welcomes comments on this proposed guidance. To the extent this guidance summarizes policies proposed through rulemakings that have not yet been finalized, such as the HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule (proposed 2027 Payment Notice),[4] interested parties should comment on those underlying policies through the ongoing rulemaking process, and not through the comment process for this 2027 Draft Letter. Please send comments on other aspects of this 2027 Draft Letter to PMpolicy@cms.hhs.gov by March 23, 2026. Comments would be most helpful if organized by the subsections of this 2027 Draft Letter.

2024 Final Letter to Issuers in the Federally-facilitated Marketplaces (May 1, 2023), *available at*: https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf; 2025 Final Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 10, 2024), *available at*: https://www.cms.gov/files/document/2025-letter-issuers.pdf; 2026 Final Letter to Issuers in the Federally-facilitated Marketplaces (Jan. 15, 2025), *available at*: https://www.cms.gov/files/document/final-2026-letter-issuers.pdf.

[2] Plan years in the FF-SHOPs will not always align with calendar year 2027.

[3] *Available at*: https://ecfr.federalregister.gov/current/title-45.

[4] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program; Proposed Rule; CMS-9883-P (Feb. 11, 2026). *See* 91 FR 6292, *available at*: https://www.federalregister.gov/documents/2026/02/11/2026-02769/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and#addresses.

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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 while the State is enforcing the insurance market reforms added to the Public Health Service (PHS) Act by the ACA, or by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA); (2) States performing plan management functions and making QHP certification recommendations to CMS and where the State does not enforce insurance market reforms added to the PHS Act by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA;[5] (3) States where CMS is performing all plan management functions and certifying QHPs while the State is enforcing the insurance market reforms in the PHS Act, and; (4) States where CMS is performing all plan management functions and where the State does not enforce insurance market reforms added to the PHS Act by the ACA,[6] or by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA.[7] Additional information and instructions about the process for issuers to complete a QHP application can be found at https://www.qhpcertification.cms.gov.

Section 1. QHP Certification Process

CMS expects issuers and State regulatory authorities in States with Exchanges using the Federal platform applying for QHP certification to adhere to the forthcoming Plan Year 2027 Qualified Health Plan (QHP) Data Submission and Certification Timeline.

Issuers will submit a complete QHP application for plans they intend to have certified in a State in which an FFE is operating.[8] CMS will review QHP applications for all issuers applying for

[5] 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.
[6] The list of States that do not enforce the ACA market wide-requirements is available at: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html.
[7] SBE-FPs retain the authority and primary responsibility for the certification of QHPs and should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this 2027 Draft Letter.
[8] *See* CMS-10433, "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," (OMB Control Number 0938-1187).

QHP certification in an FFE[9] 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.

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.[10] 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 (QHP Certification Agreement) and a Senior Officer Acknowledgement.[11] 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 2027 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.[12]

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 2027 QHP Data Submission and Certification Timeline and to make necessary updates to the QHP application before the last deadline for issuer submission. Additionally, issuers must comply with any applicable CMS requirements

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

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

[11] The documents will apply to all QHPs offered by a single issuer in an FFE at the HIOS Issuer ID l 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.

[12] 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 to QHPs that meet minimum QHP certification standards but are not ultimately in the "interest" of qualified individuals and qualified employers.

related to rate and form filings. There are certain States where CMS is directly performing rate review and/or enforcing other applicable PHS Act requirements.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.[13] All issuers must also register for the Plan Management (PM) Community to receive relevant communications regarding their QHP applications.[14]

Issuers applying for QHP certification in FFEs, excluding those in States performing plan management functions, must submit their QHP applications in the Marketplace Plan Management System (MPMS) module of HIOS.[15] Issuers in States performing plan management functions should submit QHP applications in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF) in accordance with State and CMS review deadlines, and may have additional required submissions in MPMS.[16] 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.[17]

All issuers applying for QHP certification for the 2027 plan year must validate their QHP application data in the Plan Validation Workspace (Workspace). The Workspace is the section within MPMS in which issuers upload and validate QHP application templates prior to submission. The Workspace will validate template data for data integrity and compliance with a variety of Federal standards and allow issuers to view and update pre-submission review results. Issuers will be able to submit their applications to CMS via the HIOS MPMS Module or to their State via SERFF after all validation errors are resolved. CMS encourages issuers to review frequently asked questions about the MPMS system at https://www.qhpcertification.cms.gov/s/MPMS%20FAQs.

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[13] *See* additional information on HIOS registration, which is contained in the HIOS Portal User Manual. The HIOS Portal User Manual is *available at:* https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-User-Manual.pdf. CMS expects issuers to use the same HIOS plan identification numbers for plans, including SADPs, submitted for certification for the 2027 plan year that are the same as plans, including SADPs, certified as QHPs for the 2026 plan year, as "plan" is defined in 45 CFR 144.103 and pursuant to 45 CFR 147.106. While § 147.106 is not applicable to issuers of SADPs, CMS expects that SADP issuers' HIOS plan identification numbers will be the same for the 2027 plan year if the plan has not changed since the SADP was certified for the 2026 plan year, even if the plan has been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental essential health benefit (EHB) at a specified actuarial value (AV). The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to 45 CFR 155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for the 2027 plan year that had been certified for the 2026 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

[14] For issuers not currently participating in the PM Community, please refer to the Register for Updates webpage for more information, *available at*: https://www.qhpcertification.cms.gov/s/Register%20for%20Updates.

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

[16] While some States in which an FFE is operating use SERFF to collect plan data, which may include copies of the QHP templates, that data will not be submitted to CMS in States that do not perform plan management functions and must be submitted in HIOS.

[17] 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.

CMS encourages issuers to access Plan Preview in MPMS to review plan data, verify that their plan display reflects their State-approved filings, and identify and correct data errors before the QHP application data submission deadline. Issuers can use Plan Preview to check their plan benefit data display for most enrollment scenarios, including service areas, cost sharing for benefits, and URLs, including payment redirect.

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

Section 3. QHP Data Changes

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

Table 1.1 on the next page 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 a plan's metal level, plan type, or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child- only plan. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to State or CMS feedback until the deadline for issuer changes. CMS will monitor all data changes and contact issuers if there are concerns about changes made.

Table 1.1 Allowable Data Changes by Submission Deadline

	Permitted with No State or CMS Authorization Required	**Permitted with Authorization***	**Not Permitted**
Before the Initial Submission Deadline	All data changes permitted.	N/A	N/A
Between the Initial and Final Data Submission Deadlines	All changes are permitted, including changes in response to CMS-identified corrections, except as noted here and above.	N/A	Issuers may not: • Add new plans to a QHP application; • Change an off-Exchange plan to

	Permitted with No State or CMS Authorization Required	Permitted with Authorization*	Not Permitted
			be both on and off-Exchange; • Change a plan's metal level, plan type, or market type; or • Change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan.
After the Final Submission Deadline	N/A	Issuers may request critical data changes to align with State filings. URLs (with the exception of transparency in coverage and interoperability URLs) may be changed with applicable State authorization; CMS authorization is not required.	Issuers may not change certified QHP data without the explicit direction and authorization of CMS and the State.

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

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

After the Final Submission Deadline for issuer changes to QHP applications, issuers can only make corrections directed by CMS or by their State. States may direct issuers to submit a data change request to CMS that documents State-approved corrections. If CMS approves the data change request, then CMS will open a submission window for the issuer to submit the approved corrections. Issuers whose QHP applications are not accurate after the final deadline for issuer changes to the QHP application, and are then required to resubmit corrected data during a limited

data correction window, may be subject to compliance action by CMS.[18] Issuer changes made in a limited data correction window not approved by CMS and/or the State may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

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

A request for a data change after the final submission deadline, excluding administrative 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 an issuer's QHP application and approved State filings may result in a plan not being certified or in compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on HealthCare.gov until the data are corrected and refreshed for consumer display.

Section 4. QHP Review Coordination with States

Each State will define the relevant submission window for State-level reviews as well as dates and processes for corrections and resubmissions. CMS will rely on States with an Effective Rate Review Program's reviews of issuer-submitted rate filings for reasonableness and compliance with market-wide standards as part of its QHP certification process, provided that States complete the reviews in a manner consistent with FFE operational timelines.[19] States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.[20] Similarly, CMS, as part of its QHP certification process, will rely on States' reviews of issuer-submitted policy forms for compliance with Federal laws and regulations for which the State has enforcement authority, provided that States complete the reviews in a manner consistent with FFE operational timelines.[21] Issuers in States that do not review policy forms for compliance with all applicable

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

[19] CMS will be responsible for reviewing the 2027 plan year rate filings in three States that do not have an Effective Rate Review Program (Oklahoma, Tennessee, and Wyoming).

[20] *See* Bulletin: Timing of Submission of Rate Filing Justifications for the 2026 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2027 that will be available at: https://www.cms.gov/marketplace/resources/regulations-guidance#Review-of-Insurance-Rates.

[21] States are the primary regulators of health insurance issuers and are responsible for enforcing the consumer protections and market reform provisions amended or extended by the ACA and CAA, as well as other Federal requirements, in title XXVII of the PHS Act, both inside and outside the Exchanges. Under sections 2723 and 2761 of the PHS Act and regulations codified at 45 CFR Part 150, CMS is responsible for enforcing the provisions of Parts A, B, and D of title XXVII of the PHS Act with respect to health insurance issuers in the individual and group markets when the State informs CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the applicable statutory provisions, or if CMS determines that the State is not substantially enforcing one or more of the applicable provisions. As necessary, CMS will provide additional

Federal requirements should consult forthcoming guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.[22]

When States perform QHP certification reviews,[23] they may exercise reasonable flexibility in their application of CMS' QHP certification standards, provided that the State's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in States that are performing plan management functions in the FFEs should continue to refer to State direction in addition to this guidance.

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

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

For States performing plan management functions in the FFEs, the SERFF data transfer deadlines will align with the HIOS submission deadlines. These State transfers should include all

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information on enforcement. CMS reviews form filings from issuers in Missouri, Oklahoma, Tennessee, Texas, and Wyoming (ACA enforcement States) for compliance with the ACA market reform provisions and other applicable Federal requirements in title XXVII of the PHS Act that CMS is responsible for enforcing. In addition, CMS is reviewing form filing submissions for compliance with certain CAA provisions from issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, 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.

[22] Refer to the forthcoming guidance from the Center for Consumer Information and Insurance Oversight, CMS: Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2027 that will be available at https://www.cms.gov/marketplace/resources/training#Health_Insurance_Market_Reforms.

[23] 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.

plans submitted to the State for certification, including SADPs for off-Exchange sale.[24] CMS understands that all State reviews might not be complete by the submission deadlines, but as stated above, CMS requires State confirmation of approval of QHPs for sale before CMS certification.

All States are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to State guidelines separate from Federal guidelines during certification. States must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the State plan confirmation deadline in the Plan Year 2027 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 that plan to offer Exchange coverage for the upcoming plan year are required to submit plan ID crosswalk data for each individual market QHP that was certified and offered on the Exchange for the current plan year. These data will facilitate enrollment transactions from CMS to the issuer for enrollees in an individual market Exchange who have not actively selected a different QHP or terminated their coverage during Open Enrollment.

New issuers should not submit Plan ID Crosswalk Templates to complete their application unless they will receive plans from a discontinuing issuer, which is a rare situation. However, new issuers must complete the questions in the Plan ID Crosswalk application section and submit the Plan Crosswalk application group in the MPMS Module. Issuers are required to provide alternative plans to crosswalk enrollees who age off child-only plans and alternatives for those who age off or otherwise lose eligibility for catastrophic plans. CMS has deferred the FF-SHOP's ability to auto-renew employees, so issuers do not need to submit a Plan ID Crosswalk Template for FF-SHOP plans.

Issuers can generally refer to the 2018 Letter to Issuers for more information regarding submission requirements pertinent to the Plan ID Crosswalk.[25] More recent policy changes include the requirement in the HHS Notice of Benefit and Payment Parameters for 2024 Final Rule (2024 Payment Notice) that Exchanges ensure a consumer whose current year QHP is no longer available be auto re-enrolled into a QHP that has the most similar network compared to the enrollee's current QHP.[26] Please note the 2025 Marketplace Integrity and Affordability Final Rule removed a 2024 Payment Notice policy that provided an option for Exchanges to auto re-

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

[25] *See* Chapter 1, Section 3 of the 2018 Letter to Issuers in the Federally-facilitated Marketplaces, *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf.

[26] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024; Final Rule; CMS-9899-F (April 27, 2023). *See* 88 FR 25821, *available at*: https://www.federalregister.gov/d/2023-08368/p-817.

enroll CSR-eligible bronze enrollees into a silver QHP with a lower or equivalent premium after APTC, within the same product and with the same provider network as the plan into which they would otherwise have been re-enrolled, if such a plan is available.[27]

Finally, the HHS Notice of Benefit and Payment Parameters for 2025 Final Rule (2025 Payment Notice)[28] finalized a policy to require Exchanges to re-enroll enrollees in catastrophic coverage as defined in section 1302(e) of the ACA, including those who will lose eligibility for catastrophic coverage or whose current plan will no longer be available, into a new QHP for the coming plan year, to the extent permitted by applicable State law. We also added a new paragraph 45 CFR 155.335(j)(5) to establish that an Exchange may not newly auto re-enroll an enrollee into catastrophic coverage who is currently enrolled in coverage of a metal level (a non-catastrophic plan) as defined in section 1302(d) of the ACA, consistent with the practice of the Exchanges on the Federal platform.

SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106, but CMS still aims to support automatic re-enrollment for SADPs.

Section 6. Value-based Insurance Design

The approach for 2027 remains unchanged from 2021 and later years. Please refer to the 2021 Letter to Issuers for more information.

Section 7. Alternative Payment Models (APMs)

The approach for 2027 remains unchanged from 2022 and later years. Please refer to the 2022 Letter to Issuers for more information and for some possible pathways for adoption of these approaches.

Section 8. Issuer Participation for the Full Plan Year

The approach for 2027 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 9. Standardized Plan Options

In the proposed 2027 Payment Notice, we proposed to discontinue the full suite of standardized plan option policies effective for the 2027 plan year. Specifically, we proposed to remove the

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[27] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability; Final Rule; CMS-9884-F (June 25, 2025). *See* 90 FR 27110: https://www.federalregister.gov/d/2025-11606/p-414. Also *see* discussion of remaining flexibilities for State Exchanges regarding the auto re-enrollment process at 90 FR 27112, https://www.federalregister.gov/d/2025-11606/p-431. This policy change does not result in any changes to the QHP Certification process for issuers.

[28] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program; Final Rule; CMS-9895-F (April 15, 2024). *Available at*: https://www.federalregister.gov/documents/2024/04/15/2024-07274/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025.

following from our regulations: the definition of "standardized options" at 45 CFR 155.20; all requirements pertaining to standardized plan options at 45 CFR 156.201 (the requirements for FFE and SBE-FP QHP issuers in the individual market to offer these plans at paragraphs (a) and (b) as well as the requirement for these plans to meaningfully differ from one another at paragraph (c)); the differential display of standardized plan options on *HealthCare.gov* at 45 CFR 155.205(b)(1); and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a Direct Enrollment (DE) pathway to facilitate consumer enrollment through an FFE or SBE-FP at 45 CFR 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv). Finally, we proposed to cease the annual design and publication of these plans in the applicable Payment Notice for each plan year.

Nothing under this proposal would impact or preclude State-enacted standardized plan option requirements, including the requirement for issuers in the State of Oregon to offer such plans.[29] Thus, under this proposal, Oregon issuers would continue to be subject to State requirements. However, standardized plan options offered pursuant to those requirements would no longer be differentially displayed on *HealthCare.gov*, and approved web-broker and QHP issuer enrollment partners using a DE pathway to facilitate consumer enrollment through an FFE or SBE-FP would no longer be required to differentially display those standardized plan options. Nothing under this proposal would preclude State Exchanges from requiring their respective issuers to offer standardized plan options or from differentially displaying such plans on their respective enrollment platforms.

While we proposed to discontinue the requirement for issuers to offer standardized plan options, the annual design of these plans in the applicable Payment Notice for each plan year, and the differential display of these plans on *HealthCare.gov* and the DE pathways, we are not proposing to require issuers to discontinue their existing standardized plan option offerings altogether. Instead, under this proposal, FFE and SBE-FP QHP issuers would be permitted to choose whether to discontinue their existing standardized plan option offerings altogether or continue offering them with either the same or modified cost sharing, while we simultaneously discontinue the differential display of these plans and designation of these plans as standardized plan options.

Under this proposed approach, if issuers wished to discontinue their existing standardized plan option offerings altogether, they would be permitted to do so, and enrollees in these plans would be crosswalked to a different plan in accordance with the crosswalk hierarchy at 45 CFR 155.335(j). Additionally, issuers may continue offering these existing standardized plan options with the same cost sharing, and enrollees in these plans would continue to be auto-reenrolled in these plans from one plan year to the next. However, these plans would no longer be visually distinguished as standardized plan options on *HealthCare.gov* or the DE pathways. Finally, issuers may continue offering these existing standardized plan options with modified cost sharing structures, but these issuers would be subject to the requirements under the definition of "plan" at 45 CFR 144.103 and to the uniform modification requirements at 45 CFR 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its existing standardized plan option offerings, the newly modified plan that was formerly the standardized

[29] *See* Or. Admin. R. 836–053–0009.

plan option would be considered a new plan and would therefore require a new plan ID. In this scenario, enrollees would be auto re-enrolled from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be auto re-enrolled into the newly modified plan that was formerly the standardized plan option, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of "plan" at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan – thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies what was formerly a standardized plan option's cost sharing structure while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of a former standardized plan option's cost sharing results in that plan being considered the same or a different plan, enrollees would be auto re-enrolled in accordance with the crosswalk hierarchy at § 155.335(j), including reenrollment, if applicable.

Section 10. Non-Standardized Plan Option Limits

In the proposed 2027 Payment Notice, we proposed to discontinue non-standardized plan option limits and exceptions at 45 CFR 156.202 effective beginning in the 2027 plan year. Under our proposed approach, issuers would no longer be subject to the non-standardized plan option limit of two per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, in any service area at § 156.202(a) through (c), for the 2027 plan year and subsequent years. Issuers would similarly no longer be required to utilize the non-standardized plan option limit exceptions process at § 156.202(d) through (e) to offer additional non-standardized plan options given that they would no longer be limited in the number of non-standardized plan options they may offer for the 2027 plan year and subsequent years. We would correspondingly remove § 156.202 from regulation.

Similar to our proposed approach to discontinue the requirement for issuers to offer standardized plan options (as well as the differential display of these plans) but not to require issuers to discontinue these existing offerings altogether, we propose to discontinue the non-standardized plan option limits and exceptions process but not to require issuers to discontinue these existing offerings altogether. Instead, under this proposal, issuers would be permitted to choose whether to discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether or continue offering them with either the same or modified cost sharing.

Under this proposed approach, issuers may discontinue the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process altogether, and enrollees in these plans would be auto re-enrolled to a different plan in accordance with the crosswalk hierarchy at § 155.335(j).

Additionally, issuers may also wish to continue offering the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process with the same cost sharing structures, and enrollees in these plans would continue to be auto re-enrolled in these plans from one plan year to the next.

Finally, issuers may wish to continue offering the chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process with modifications to the plans' cost sharing structures, but these issuers would continue to be subject to the requirements under the definition of "plan" at § 144.103 and to the uniform modification requirements at § 147.106.

In most scenarios where an issuer modifies the cost sharing structure of one of its chronic and high-cost condition plans originally offered through the non-standardized plan option limit exceptions process, the newly modified plan that was formerly the non-standardized plan option limit exceptions process plan would be considered a new plan and would therefore require a new plan ID.

In this scenario, enrollees would be auto re-enrolled from the discontinued plan to another plan in accordance with the crosswalk hierarchy at § 155.335(j). These enrollees could be auto re-enrolled into the newly modified plan that was formerly the non-standardized plan option limit exceptions process plan, or an entirely different plan altogether, depending on the unique circumstances in each county.

However, under the definition of "plan" at § 144.103, a State may permit issuers to make greater changes to a plan's cost sharing while still permitting that plan to be considered the same plan – thus maintaining the same plan ID. Furthermore, pursuant to § 147.106(e)(3)(iv), as long as the variation in cost sharing is solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level (and other applicable requirements under § 147.106(e) are met), the modifications could be considered uniform (thus, a viable exception to guaranteed renewability).

In the scenario where an issuer modifies the cost sharing structure of what was formerly a non-standardized plan option limit exceptions process plan while maintaining the same plan ID, enrollees in the plan would be auto-reenrolled from one plan year to the next. In either case, whether the modification of the cost sharing structure of a former non-standardized plan option limit exceptions process plan results in that plan being considered the same or a different plan, enrollees would be auto re-enrolled in accordance with the crosswalk hierarchy at § 155.335(j), including reenrollment, if applicable.

Section 11. Requests for Reconsideration of a Denial of Certification

The approach for reconsidering an issuer's denied QHP certification remains unchanged from 2026. Pursuant to 45 CFR 155.1090, the FFEs permit an issuer that has submitted a complete application to an FFE for certification of a health plan as a QHP and is denied certification to request reconsideration of such action. An issuer submitting a request for reconsideration must submit a written request for reconsideration to HHS, in the form and manner specified by HHS, within 7 calendar days of the date of the written notice of denial of certification. The issuer must

include any and all documentation the issuer wishes to provide in support of its request with its request for reconsideration. We finalized in the HHS Notice of Benefit and Payment Parameters for 2026 Final Rule (2026 Payment Notice)[30] that for HHS' denial decision to be overturned, a request for reconsideration must provide clear and convincing evidence that HHS' determination that the plan does not meet the general certification criteria at 45 CFR 155.1000(c) was in error.

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

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

This chapter provides an overview of key QHP certification standards for QHPs, including SADPs, in FFEs, including those in States performing plan management functions, and how CMS or the State will evaluate and conduct reviews of 2027 QHPs, including SADPs, for compliance.

Section 1. Licensure and Good Standing

The approach for licensure and good standing remains unchanged from 2018 and later years. Please refer to the Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Exchanges for Plan Years 2018 and Later ("State Guidance on QHP Reviews") for more information.[31] As noted in the State Guidance on QHP Reviews, CMS does not review issuers' compliance with licensure and good standing standards. In FFEs, including in States performing plan management functions, States will continue to ensure issuer compliance with 45 CFR 156.200(b)(4).

Section 2. Service Area

The approach for reviews of service area remains unchanged from 2023. Please refer to the 2023 Letter to Issuers for more information. 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 2027 QHP Data Submission and Certification Timeline, a data change request is required for any change to QHP data, including service area.

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[30] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program; Final Rule; CMS-9888-F (January 15, 2025). *Available at*: https://www.federalregister.gov/documents/2025/01/15/2025-00640/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2026-and

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

Section 3. Network Adequacy

i. Network Adequacy for QHP Issuers that Use a Provider Network in FFEs

As described in the proposed 2027 Payment Notice, in recognition of the crucial role of States in developing and enforcing network adequacy standards and because CMS believes States are often best positioned to evaluate local provider networks and market conditions, CMS proposed at 45 CFR 155.1050(d) to allow for FFE States, including States that perform plan management, to elect to conduct reviews for provider access for QHP issuers that use and do not use a provider network, provided that the State demonstrates sufficient authority and the technical capacity to conduct the reviews by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program as described at the proposed § 155.1050(d)(2) through (d)(4). In States with an FFE that do not elect to conduct provider access reviews or do not demonstrate sufficient authority and the technical capacity by satisfying the applicable criteria to be considered to have an Effective Provider Access Review Program, CMS would continue to conduct network adequacy reviews for QHP issuers that use a provider network using the Federal standards consistent with the proposed, revised § 156.230(a)(1) through (a)(4) including time and distance and appointment wait time standards.

More information on the proposal to allow for certification of non-network plans as QHPs can be found in the proposed 2027 Payment Notice as well as Chapter 2, Section 3(i)(c) "Non-Network Plans" of the 2027 Draft Letter to Issuers for provider access reviews and in Chapter 2, Section 4 "Essential Community Providers" of the 2027 Draft Letter to Issuers for Effective Essential Community Provider Review Program reviews.

Because the FFE has economies of scale in the collection and analysis of various forms of network adequacy data, including time and distance data and appointment wait time data, CMS would continue collecting provider data during QHP certification via the Network Adequacy Template submitted to the MPMS from all FFE issuers, regardless of whether the FFE issuer is operating in a State with an Effective Provider Access Review Program. CMS would not use the Network Adequacy Template data that QHP issuers that use a provider network submit in States with an Effective Provider Access Review Program to make decisions about QHP Certification as it relates to network adequacy. However, CMS would make this data available in a standardized format to interested States as a supplement and would use it for continued support to other ongoing programs including Appointment Wait Time Provider Population File generation. In those States without an Effective Provider Access Review Program, CMS would continue to review issuer submitted data for network adequacy during QHP certification.

For QHP issuers that use a provider network in FFE States determined to have an Effective Provider Access Review Program, CMS would defer to the QHP issuer's respective State Department of Insurance for the specific network adequacy requirements applicable for QHP certification.

a. Time and Distance Standards

The time and distance standards remained unchanged from 2023. The methodology remains unchanged from 2026 for only those QHP issuers that use a provider network in FFE States that

do not elect to conduct provider access review or States that do not demonstrate they have the authority or technical capacity by satisfying the criteria for an Effective Provider Access Review Program as described at the proposed 45 CFR 155.1050(d). Please refer to the 2023 and the 2026 Letter to Issuers, respectively, for more information.

Telehealth for Time and Distance Standards

The approach for telehealth services for time and distance standards in 2027 remains unchanged from 2023 and later years. Please refer to the 2023 Letter to Issuers for more information.

b. Appointment Wait Times

The approach for appointment wait time standards remains unchanged from 2025 for all QHP issuers. This would include any FFE States determined to satisfy the applicable criteria to be considered to have an Effective Provider Access Review Program, if the policy is finalized as proposed. Please refer to the 2025 Letter to Issuers for more information. Medical QHP issuers in the FFEs are subject to secret shopper survey requirements explained more fully in the Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs).[32]

c. Non-Network Plan Provider Access Requirements

In the proposed 2027 Payment Notice, CMS proposed to rescind the requirement that all plans must use a network of providers and has instead proposed to allow plans that do not use a network (non-network plans)[33] to obtain QHP certification by demonstrating sufficient access to a broad range of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of the ACA. As with plans that use a network of providers, FFE States that CMS determines have an Effective Provider Access Review Program would conduct provider access reviews of non-network plans, should the State deem to certify such plans.

At newly proposed 45 CFR 156.236(a), we propose that a non-network QHP would be required to ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay. If finalized as proposed, CMS would conduct provider access reviews for non-network plans in States that do not elect to conduct provider access reviews or have not been determined to have an Effective Provider Access Review Program under proposed 45 CFR 155.1050(d).

FFE States that have been determined to have an Effective Provider Access Review Program would be able to consider additional factors the State may find relevant in considering whether

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[32] *See* Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs) (April 2024), *available at*: https://www.cms.gov/files/document/awt-sss-tech-guide-qhp-ffe-508.pdf.

[33] A non-network plan includes a plan that does not have a network of providers and does not condition or differentiate benefits based on whether the issuer has a network participation agreement with a provider that furnishes covered services. The plan sets specified benefit amounts for covered services and communicates those benefit amounts to its enrollees.

the plan should be certified as a QHP. Non-network plans that are QHPs would also need to structure their plans to ensure those plans provide all consumer protections contained in market-wide provisions.

Additional ECP requirements would apply to non-network plans which are detailed in Chapter 2, Section 4 "Essential Community Providers" of the 2027 Draft Letter.

d. General Attestation Requirements for Non-Network Plans

If finalized as proposed, non-network plans would be required to satisfy additional factors in proposed 45 CFR 156.236(b)(1) and (b)(4) through (b)(9) to enable CMS to determine whether the plan provides a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full so that services would be accessible without unreasonable delay. Accordingly, a non-network plan applying for QHP certification to be offered through an FFE would be required to attest "Yes" or "No" to each of the following questions within their application in the Plans and Benefits Section in MPMS:

- Does your plan have an assessed percentage of available providers in each plan's service area that accept the plan's benefit amount as payment in full that ensures access to a sufficient choice of providers consistent with Section 1311(c)(1)(B) of the ACA?
- Does your plan make benefit amounts available publicly to the public, including plan enrollees, potential enrollees, and providers (including ECPs) in an easily accessible and understandable format?
- Does your plan provide consumer-friendly and public information about potential balance billing scenarios and expected out-of-pocket costs, including historical data on actual out-of-pocket costs incurred by its enrollees while accessing providers (including ECPs) in the area?
- Does your plan have a methodology for determining benefit amounts?
- Does your plan have an exceptions process for enrollees who cannot find providers (including ECPs) willing to accept the plan's benefit amounts as payment in full?
- Does your plan have a strategy and process for providing adequate customer service, an online provider directory, or assistance resources to assist plan enrollees and potential enrollees in finding providers (including ECPs) in their area who will accept the plan's benefit amount as payment in full?
- Does your plan have a strategy for conducting continuous outreach to available providers (including ECPs) in your plan's service area to determine whether they would accept the plan's benefit amount as payment in full and the effective timeframe of the agreed-upon payment amounts?

In addition, QHP issuers offering non-network plans would be required to provide in their QHP application a publicly available URL in an easily accessible and understandable format where the public, including plan enrollees, potential enrollees, and providers (including ECPs), can access information about all available plan benefit amounts. This benefit amount information would be considered easily accessible when the general public is able to view all of the benefit amounts associated with a plan on the issuer's public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number. If an issuer offers multiple non-network plans with benefit amounts that differ from plan to plan, the general public should be able to easily discern which benefit amounts apply to each plan. Altogether, CMS would

assess these aforementioned requirements above, in addition to ECP and provider access certification requirements specific to non-network plans under § 156.236(b)(1) through (b)(3), to determine whether non-network plans fully satisfy certification requirements under proposed § 156.236.

Section 4. Essential Community Providers

At 45 CFR 156.235, CMS established QHP issuer requirements for inclusion of essential community providers (ECPs) in provider networks, which require that issuers include at least a certain threshold percentage, as determined by HHS, of available ECPs (based on a non-exhaustive HHS ECP List provided to issuers and updated annually) within the plan's service area in the issuer's provider network(s). Please refer to the 2024 Letter to Issuers for full details of the ECP standard and CMS' approach for conducting certification reviews. The ECP standard for the 2027 plan year will remain the same as for the 2024 plan year, with the exception of the changes noted below.

i. Non-Network Plan ECP Requirements

CMS proposed in the proposed 2027 Payment Notice to rescind the existing blanket prohibition of non-network plans to obtain QHP certification by demonstrating sufficient access to a broad range of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of the ACA. This would include needing to provide reasonable and timely access to a sufficient number of ECPs that accept the non-network plan's benefit amount as payment in full, and meeting ECP standards for non-network plans at proposed § 156.236. CMS believes that providing the Exchanges with an ability to assess these plans and their adherence to a provider access sufficiency standard would promote innovation within the Exchanges, and if successful, contribute to a more competitive consumer-driven marketplace that leverages price transparency principles. A non-network plan applying for QHP certification to be offered through an FFE would be required to satisfy the criteria detailed in the paragraphs below.

Similar to network plans, non-network plans would be required to ensure access to ECPs, where available, that serve predominantly low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Non-network plans would be required to adhere to ECP standards, including for threshold, category per county, and Indian health care provider requirements, that are comparable to network plans under § 156.235. However, in lieu of ECP requirements for network plans that require QHP issuers to demonstrate both fully executed contracts and contract offers made to available ECPs within each network and service area to receive credit toward satisfaction of the ECP standard, non-network plans would be required to instead demonstrate that available ECPs in their service area have accepted and been offered the plan's benefit amount as payment in full. Specifically, a non-network plan applying for QHP certification to be offered through an FFE would be required to:

- Meet at least a minimum percentage, as specified by HHS, of available ECPs that accept the plan's benefit amount as payment in full in each plan's service area collectively across all ECP categories defined under § 156.235(a)(2)(ii)(B), and at least a minimum percentage of

available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. For the 2027 plan year and thereafter, CMS proposed in the proposed 2027 Payment Notice to reduce this minimum percentage from 35 to 20 percent for network plans, and this reduced minimum percentage would similarly apply for non-network plans. Similar to network plans, non-network plans would need to meet this 20 percent minimum percentage requirement for the overall threshold, Federally Qualified Health Center (FQHC) threshold, and family planning provider threshold requirements such that:
    - At least 20 percent of all the available ECPs in the plan's service area accept the plan's benefit amount as payment in full; and
    - At least 20 percent of all the available FQHCs in the plan's service area accept the plan's benefit amount as payment in full; and
    - At least 20 percent of all the available family planning providers in the plan's service area accept the plan's benefit amount as payment in full.
- Additionally, non-network plans would be required to meet the ECP Category per county requirement: Offer the benefit amount as payment in full to at least one ECP in each of the eight (8) ECP categories per county in the plan's service area described in § 156.235(a)(2)(ii)(B).
- Lastly, non-network plans would be required to meet the Indian health care provider requirement: Offer the benefit amount as payment in full to all available Indian health care providers in the plan's service area.

In order for non-network plans to demonstrate satisfaction with each of these aforementioned threshold, category per county, and Indian health care provider requirements under proposed § 156.236(b)(1)-(3), non-network plans would be required to select ECPs that would accept their benefit amount as payment in full in their QHP application within the ECP User Interface (UI) in the MPMS. The list of ECPs that non-network plans would be required to select from include qualifying ECPs that CMS approved for inclusion on the Final Plan Year ECP List. For each ECP selected, non-network plans would be required to append a facility status to enable CMS to determine the issuer's satisfaction of each of the ECP requirements during certification reviews. The facility status options from which non-network plans would be required to select for an ECP within their service area for which they are attempting to offer their benefit amount as payment in full are as follows:

- Accepted benefit amount as payment in full.
- Awaiting response for benefit amount offered as payment in full.
- Rejected offer for benefit amount as payment in full.
- Benefit amount as payment in full was not offered due to no response following issuer outreach.
- Did not offer a benefit amount as payment in full.
- Facility closed.
- No medical service provided.
- No dental services provided.
- Not licensed or certified by the State.
- Facility has relocated outside the service area.
- Facility has no interest in contracting with or accepting payment from commercial insurance.
- Facility has one or more incorrect ECP categories.

Lastly, additional provider access requirements and general attestation requirements would apply to non-network plans which are detailed in Chapter 2, Section 3 "Network Adequacy" of the 2027 Draft Letter to Issuers.

ii. Reduction of the ECP Threshold Requirements from 35 to 20 percent

In the proposed 2027 Payment Notice, CMS proposed that for the 2027 plan year and in the future, CMS will decrease the minimum percentage requirement from 35 to 20 percent for the overall threshold, the FQHC threshold, and the family planning provider threshold in FFEs, including States performing plan management. The minimum percentage requirement, also referred to as the "ECP threshold requirement," specifies the minimum percentage of participating ECPs that network plan issuers would be required to include in their provider network based on the total available ECPs within the issuer's service area. For all QHP issuers, including SADP issuers, applying under the general ECP standard at § 156.235(a), CMS' proposal will determine issuer satisfaction of the 20 percent overall threshold requirement by measuring the numerator based on the issuer's contracted ECPs listed in the QHP application that consist of any qualified ECPs located within the plan's service area, and the denominator will consist of all available and qualified ECPs located within the plan's network service area. In accordance with both general and alternate ECP standards, CMS would measure only contracted FQHCs based on those included in the issuer's QHP application and those available and qualified FQHCs located within the medical QHP and SADP issuer's network service area for purposes of determining satisfaction of the FQHC threshold requirement. Similarly, CMS would measure only contracted family planning providers based on those included in the issuer's QHP application and those available and qualified family planning providers located in the medical QHP issuer's network service area for purposes of determining satisfaction of the family planning threshold requirement.

For Alternate ECP standard issuers applying under § 156.235(b), CMS proposes to determine issuer satisfaction for each of the 20 percent threshold requirements similar to the approach for general ECP standard issuers. However, CMS would instead consider the alternate ECP standard issuers' employed or contracted providers as ECPs, including any allowable providers that the issuer has listed in its QHP application that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population whose income falls below 200 percent of the Federal poverty level. As stated in the proposed 2027 Payment Notice, while we propose to lower the ECP threshold requirements for each of these three thresholds, we recognize that a majority of issuers have exercised and will continue to exercise the flexibility to exceed the proposed minimum percentage requirements within their provider networks.

Like previous years, after the Final Plan Year ECP List[34] is finalized, issuers applying under the General ECP Standard under § 156.235(a), will receive credit toward satisfying the standard for any write-in ECPs included in their network. Write-in ECPs are qualified facilities that are

[34] The Final Plan Year ECP List is a static list of available, qualified ECPs that assists issuers by identifying facilities that would count toward satisfaction of the ECP Standard at the start of QHP certification, in accordance to § 156.235, if included in an issuer's network. The Final Plan Year ECP List is updated annually and can be found under Application Resources within the ECP page of the QHP certification website (https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Essential-Community-Providers).

approved by CMS as eligible ECPs after the Final ECP List submission deadline, so they are not included in the Final Plan Year ECP List, but added to the Rolling Draft ECP List[35] and List of Available ECP Write-ins[36] for issuers to recruit if they chose. Alternate ECP standard issuers will receive credit for including custom write-in ECPs in their network. Furthermore, similar to previous years, multiple providers at a single street location will count as one ECP toward the available ECPs in the plan's service area and toward the issuer's satisfaction of the ECP threshold requirements to ensure a sufficient number and geographic distribution of ECPs as required under § 156.235. Lastly, as with previous years, issuers will receive credit for in-network or contracted ECPs designated as contract executed within the issuer's application in CMS' assessment of the issuer's satisfaction of the ECP threshold requirements.

iii. Clarification of Narrative Justification Requirements and the Use of Contract Negotiation Fields within the ECP section in MPMS

In the proposed 2027 Payment Notice, CMS proposed to modify the regulation text at § 156.235(a)(3) and (b)(3) that requires an issuer to include a narrative justification as part of their QHP application if not satisfying the ECP standard. Due to the implementation of multiple refinements and modernizations to the ECP data collection and submission, including embedding justification-related information into the ECP UI in MPMS, CMS would no longer require issuers to submit narrative justifications during QHP certification. Instead of issuers submitting a narrative justification for not satisfying the ECP standard as was previously required under § 156.235(a)(3) and (b)(3), issuers would be required to include, as part of their QHP application, the status of contract offers to qualified ECPs available in the network plan's service area, consistent with current operations and ECP data submission requirements collected as part of ECP certification reviews. A network plan would not need to report on the status of contract offers for all available ECPs in the network plan's service area, but would be required to at least report on the status of contract offers for all ECPs which the issuer has either included in its network plan or offered a contract to be included in its network plan within each service area. MPMS allows CMS to collect the same type of information previously obtained from the narrative justifications without having to require issuers to fill out long narrative explanations.

There are no substantive operational changes to ECP data submission requirements for issuers as part of QHP certification with these proposed regulation text revisions. Issuers should continue

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[35] The Rolling Draft ECP List is a dynamic list of ECPs that is updated regularly to reflect changes in the ECP landscape, including facility information updates, newly approved ECPs, removal of ineligible ECP facilities, updates to services provided at ECPs, etc. This list often contains the most recent information, particularly information following the release of the annual Final Plan Year ECP List. The Rolling Draft List can be found here: https://data.healthcare.gov/rolling-draft-list.

[36] The List of Available ECP Write-ins is a specific list of qualified ECP facilities approved after the deadline for inclusion on the Final ECP List. These Write-In ECPs are included on the Rolling Draft ECP List but were not reflected on the Final Plan Year ECP List. Issuers can receive credit for contracting with these available ECP Write-ins during QHP certification, but issuers will not be penalized for not contracting with them. These ECPs will be embedded within the ECP Write-In section in MPMS (for General ECP Standard issuers), are updated regularly in sync with the Rolling Draft ECP List, and this list can be found under 'Application Resources' within the ECP page of the QHP certification website (https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Essential-Community-Providers).

to designate the following contract negotiation statuses to ECPs within their network and service areas as part of their QHP applications, as appropriate:

- Contract executed: if the issuer has already contracted with this provider.
- Contract offer made, awaiting response: if the issuer has offered a contract to a provider and is waiting for a response.
- Pre-contract negotiations in progress (contract offer not made yet): if the issuer and provider are still developing contract terms and conditions.
- Offer rejected: if the provider rejects the issuer's contract offer.
- Contract not offered due to no response following issuer outreach: if the provider has not responded to repeated contract offers.
- Facility closed: if the provider is no longer in business.
- Facility has no interest in contracting with or accepting payment from commercial insurance: if the provider sites state they do not accept any commercial insurance as a reason for rejecting the contract.
- No medical services provided: if the facility does not provide medical services and provides only dental services.
- No dental services provided: if the facility does not provide dental services and provides only medical services.
- Exclusivity contract prohibits us from contracting with facility: if the provider is prevented contractually from contracting with other issuers.
- Not licensed or certified by the State: if the provider meets any of these restrictions.
- Facility has relocated outside the service area: if the provider has moved out of the issuer's declared service area, preventing the issuer from contracting with the facility.
- Facility has one or more incorrect ECP categories: if one or more of the ECP categories listed under an ECP are not correct or the ECP no longer offers those categories of services.

Issuers designating their contract negotiation status as contract executed for an ECP will receive credit for that contract towards satisfaction of meeting the ECP Standard as part of threshold, ECP category per county, and Indian health care calculations, as applicable. Specifically, for the ECP category per county and Indian health care provider requirements, which is calculated based on contract offers instead of only contracts executed, issuers who designate that a contract offer was rejected or contract offer was made but awaiting response will receive credit towards satisfaction of these two requirements, in addition to designating that a contract was fully executed. Issuers who designate a high volume of the other contract negotiation statuses for either of the ECP requirements will receive corrections to their QHP application if not meeting the different elements of the ECP standard. In these cases, issuers should continue their outreach efforts by offering contracts in good faith to other available ECPs in their service area. If outreach efforts with a certain provider are not successful, issuers would need to vary their communication efforts such as utilizing phone, mail, or email to reach providers: including calling at different times during the day (i.e., a facility may have only morning or afternoon hours), different days of the week (i.e., a facility may be open only certain days of the week), and using phone calls, emails, and letters. Issuers not meeting the ECP standard would be encouraged to document these provider recruitment efforts in case they are requested by CMS to submit additional ECP data following the final QHP submission deadline as part of compliance reviews.

iv. Implementation of an Effective Essential Community Provider Review Program (45 CFR 155.1051)

In the proposed 2027 Payment Notice, CMS proposed that beginning with the 2027 plan year, we would allow FFE States, including States performing plan management, to elect to conduct their own ECP certification reviews of issuers' plans with or without a provider network applying for QHP certification as a QHP to be offered through a Federally-facilitated Exchange provided that the State demonstrates it has sufficient authority and the technical capacity to conduct these reviews by satisfying the applicable criteria to be considered to have an Effective Essential Community Provider Review Program under proposed new 45 CFR 155.1051. We believe this would empower FFE States with more authority over the operation and enforcement of certification requirements, including ECP requirements, and recognize the unique knowledge that States have on local factors that could strengthen ECP certification reviews. An FFE State would need to demonstrate that it meets applicable criteria for both network plans and non-network plans to receive a designation as an Effective ECP Review Program. However, if an FFE State notifies HHS that it would not certify non-network plans and consequently not allow these plans to be offered on the FFE operating in that State, then HHS would continue to review whether an FFE State meets all applicable criteria for only network plans during the Effective ECP Review Program determination process. FFE States would also have an ability to elect to conduct their own ECP certification reviews, Provider Access certification reviews (described under Chapter 2, Section 3 of this 2027 Draft Letter), or both review types, provided the FFE State satisfies the applicable criteria for each applicable review program it wishes to conduct. If CMS determines an FFE State does not have an Effective ECP Review Program or an FFE State does not express interest in performing ECP certification reviews, then we would continue to perform federal ECP certification reviews consistent with § 156.235 for network plans and § 156.236 for non-network plans.

Additionally, FFE States would be required to submit their attestation to demonstrate they meet requirements under § 155.1051 to receive the Effective ECP Review Program designation prior to the start of the QHP certification cycle for the first plan year they wish to assume responsibility to conduct ECP certification reviews, which typically begins in April of each year. In subsequent years, HHS would reach out to FFE States with an Effective ECP Review Program prior to the start of the QHP certification cycle each year to confirm if these States wish to continue conducting their own ECP certification reviews for the upcoming plan year and to verify if any circumstances have changed that may affect an FFE State's authority and technical capacity to continue conducting effective reviews of ECP data.

In addition, CMS would continue collecting ECP data from issuers in FFE States with an Effective ECP Review Program but would not conduct extensive Federal ECP certification reviews of these issuers since the FFE States would instead assume this responsibility. QHP issuers in FFE States with an Effective ECP Review Program would still validate and submit ECP data within the ECP UI in MPMS and respond to data related errors, if applicable, but would not need to undergo the extensive ECP review process at the Federal level such as by re-submitting data to address deficiencies in ECP requirements identified by CMS or submitting justifications. Continuing to collect this data on the Federal level would allow CMS to continue to comparatively assess issuer performance on different ECP requirements across the FFE and make this data available to FFE States in a standardized format that could be leveraged for

additional analyses, including assessments to inform potential improvements in access to ECPs. CMS and FFE States with an Effective ECP Review Program would coordinate to communicate to QHP issuers ahead of the QHP certification cycle whether they would complete ECP certification reviews at the Federal or State-level. QHP issuers in FFE States without an Effective ECP Review Program would continue to submit ECP data in accordance with the same systems, processes, and data requirements that have been in place for the 2026 plan year and in alignment with the changes noted in this section.

Section 5. Accreditation

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

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards remains unchanged from 2017. Please refer to the 2017 Letter to Issuers for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds. CMS continues to assess patient safety standards and any related burden for issuers, providers, 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 2026[37] for more detailed information on issuer data collection and reporting requirements for the 2026 calendar year.

At this time, QRS and QHP Enrollee Survey reporting requirements do not apply to indemnity plans, SADPs, or to child-only plans offered on Exchanges. The QRS and QHP Enrollee Survey requirements also do not apply to Basic Health Program (BHP) plans.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2027 plan year.

[37] *See* Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2026 (September 2025), *available at*: https://www.cms.gov/files/document/qrs-and-qhp-enrollee-experience-survey-technical-guidance-2026.pdf.

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 BHP plans.

Section 9. Review of Rates and Forms

The approach for reviewing rate filings for the 2027 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.[38]

Issuers in States with an Effective Rate Review Program that use SERFF are able to comply with the requirement to submit rate filing justifications to CMS by submitting the rate filing directly in SERFF. A rate filing filed in SERFF is automatically uploaded to the Uniform Rate Review (URR) page of MPMS module of HIOS and will be considered filed with CMS once the upload is successful.[39] This functionality does not apply to States that do not have an Effective Rate Review Program[40] and States that do not participate in SERFF. Issuers in those States will need to continue to submit the rate filing justification directly in the MPMS module of HIOS. These same guidelines apply to issuers in States that do not perform plan management functions and otherwise submit QHP application data in HIOS.

CMS will rely on States with an Effective Rate Review Program's reviews of issuer-submitted rate filings for reasonableness and compliance with market-wide standards as part of CMS' QHP certification process, provided that States complete the reviews in a manner consistent with FFE operational timelines. States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.[41] Similarly, CMS, as part of its QHP certification process, will rely on States' reviews of issuer-submitted policy forms for compliance with Federal laws and regulations for which the State has enforcement authority, provided that States complete the reviews in a manner consistent with FFE operational timelines. Issuers in States that do not review policy forms for compliance with all applicable Federal requirements should consult guidance from CMS regarding timelines for policy form filings for the appropriate plan year coverage.[42] These issuers will have to submit two sets of policy form filings. One filing will be submitted to the State through the State instance of SERFF or in the manner specified by the State, and the second filing will be submitted to CMS through the CMS instance of SERFF.[43]

Section 10. Discriminatory Benefit Design

The approach to reviewing discriminatory benefit design remains unchanged from 2017. Please refer to the 2017 through 2026 Letters to Issuers for more information. Specifically, to ensure

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[38] *See*, e.g., the Unified Rate Review Instructions, *available at*: https://www.cms.gov/files/document/urr-py23-instructions.pdf.
[39] Ibid.
[40] *See supra* note 19.
[41] *See supra* note 20.
[42] *See supra* note 22.
[43] 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."

robust consumer protection against potentially discriminatory benefit designs, CMS will continue to review plan benefit designs to ensure they are nondiscriminatory and align with 45 CFR 156.125. CMS also coordinates with States to ensure that QHPs in the FFEs adhere to the EHB nondiscrimination policy. While enforcement of EHB policy primarily falls on the States, CMS will continue to monitor issuer compliance, provide technical assistance, and share relevant data and research.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from 2019 and subsequent years. Please refer to the 2019 through 2026 Letters to Issuers for more information. CMS will continue to conduct prescription drug reviews to ensure that QHPs are in compliance with 45 CFR 156.125 and 156.225.

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 2027 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

The approach for data integrity reviews of QHP application templates remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information. The review will identify data errors that would result in improper display of plan information to consumers as well as other template irregularities. CMS may choose to conduct outreach throughout QHP Certification with issuers that have unresolved data integrity errors.

Section 15. Requirements for Plan Marketing Names

CMS will conduct reviews of QHP plan and plan variation marketing names to ensure they include correct information, without omission of material fact, and do not include content that is

misleading.[44] More information about this review is available in the 2024 Letter to Issuers, the Plan Marketing Name Fact Sheet, and slides from the June 5, 2025 QHP Certification Webinar.[45]

Section 16. Interoperability

For the 2027 plan year, all previous year requirements for the interoperability QHP certification review remain in place; see the 2024 Letter to Issuers for more information on these requirements.[46] Additionally, CMS will incorporate several new requirements into MPMS to reflect the February 2024 CMS Interoperability and Prior Authorization final rule requirements.

Issuers can refer to the Final Rule and related technical assistance to learn more about these requirements.[47] Issuers should also refer to these materials for more information on requirements that will take effect starting with plan years that begin on or after January 1, 2027, and that CMS will incorporate into the MPMS application in future years. These requirements include those at 45 CFR 156.222(a) and (b), to build and maintain a Provider Access Application Programming Interface (API) and a Payer to Payer API; 156.223(b), to build and maintain a Prior Authorization API; and at 156.221(b)(1)(iv), to incorporate certain prior authorization information into the Patient Access API.

Like the rest of the 2024 CMS Interoperability and Prior Authorization final rule, those policies do not apply to any kind of drugs. The summary and Table 2.1 below provide additional detail on changes to MPMS for plan year 2027 QHP certification.

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[44] 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 § 156.140(b)(2), and a different name for that plan's equivalent that meets the AV requirements at § 156.420(a)(1), (2), or (3).

[45] *See* Chapter 2, Section 15 of the 2024 Final Letter to Issuers in the Federally-facilitated Exchanges, *available at*: https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf. *See* also Plan Marketing Name Fact Sheet, *available at*: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits (scroll to "Plan Marketing Name Fact Sheet"). Also *see* the June 5, 2025 QHP Certification Webinar slides, *available at*: https://regtap.cms.gov/reg_library_openfile.php?id=5407&type=l and the webinar recording, *available at*: https://regtap.cms.gov/reg_library_video.php?id=5929.

[46] *See* Chapter 2, Section 16 of the 2024 Final Letter to Issuers in the Federally-facilitated Exchanges, *available at*: https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf.

[47] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program; Final Rule; CMS-0057-F (February 8, 2024), *available at*: https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability. Technical assistance materials are *available at*: https://www.cms.gov/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f, including Frequently Asked Questions, which are *available at:* https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/faqs.

Interoperability Updates to QHP Certification for Plan Year 2027:

1. **Reporting requirements:** The 2024 CMS Interoperability and Prior Authorization final rule requires QHP issuers to start reporting Patient Access API usage metrics to CMS, and prior authorization metrics publicly, beginning with data from the 2025 plan year.[48] QHP issuers must annually report these metrics by March 31st of the subsequent calendar year (for example, report 2025 plan year metrics by March 31st, 2026). However, to streamline data reporting processes, CMS is aligning collection of the usage metrics data with the QHP certification process. That is, in the first year of the requirement, QHP issuers will report plan year 2025 data during calendar year 2026, as part of the plan year 2027 QHP certification process.

    a. Section 156.221(f) requires that FFE QHP issuers report certain Patient Access API usage metrics to CMS, in the form of aggregated, de-identified data.

    These metrics will help CMS better understand whether patients are using the Patient Access API to access their health information. We recognize that new QHP issuers may not have data to report for the previous year; issuers will be required to report these data following the first full plan year that they are subject to the Patient Access API requirement.

    b. Section 156.223(c) requires that FFE QHP issuers report certain prior authorization metrics publicly.

    CMS does not require a specific format for the prior authorization metrics, but encourages issuers to consider readability and accessibility when preparing the report. CMS has released similar metrics and a suggested template that can serve as examples.[49]

2. **Reason for prior authorization denial:** Section 156.223(a) requires that, beginning January 1, 2026, if the QHP issuer denies a prior authorization request (excluding a request for coverage of drugs), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.[50]

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[48] *See* CMS-10843, "Advancing Interoperability and Improving Prior Authorization Processes," (OMB Control Number 0938-1437); *Also see* CMS-10433, "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," (OMB Control Number 0938-1187).

[49] *See* Prior Authorization and Pre-Claim Review Statistics for Medicare Fee-For-Service: https://www.cms.gov/files/document/prior-authorization-and-pre-claim-review-program-statistics.pdf, and Prior Authorization Metrics Report - Overview & Template: https://www.cms.gov/files/document/prior-authorization-metrics-reporting-overview-template.pdf.

[50] As discussed in the Interoperability and Prior Authorization Final rule preamble, this requirement is intended to reinforce and supplement existing Federal and State notification requirements and does not alter or replace existing requirements to provide notice to patients, providers, or both. In particular, separate requirements for group health plans and issuers of group and individual health insurance coverage to provide notice to individuals of adverse benefit determination or final internal adverse benefit determination exist at 45 CFR 147.136(b)(2)(ii)(E) and 29 CFR 2560.503-1(g) and (j). *See* 89 FR 8874-8876 for preamble discussion, *available at*: https://www.federalregister.gov/d/2024-00895/p-1266.

Table 2.1 Advancing Interoperability and Improving Prior Authorization Processes Final Rule: New CMS Data Collections and Effective Dates

Requirement in CMS-0057-F	Regulatory Citation	Effective Date	New Questions in MPMS Interoperability Section for the Plan Year 2027 QHP Certification Application
Reporting on Patient Access API usage	45 CFR 156.221(f)	March 31, 2026 (to report metrics from the 2025 plan year)	**Enrollees Who Used Patient Access API** Report the total number of unique enrollees whose data are transferred at least once via the Patient Access API to a health app designated by the enrollee in the 2025 calendar year. **Enrollees Who Used Patient Access API Multiple Times** Report the total number of unique enrollees whose data are transferred more than once via the Patient Access API to a health app designated by the enrollee in the 2025 calendar year.
Publicly reporting prior authorization metrics	45 CFR 156.223(c)	March 31, 2026 (to report metrics from the 2025 plan year)	Has the issuer published prior authorization metrics publicly on its website, as required by § 156.223(c), for the 2025 calendar year? These metrics may, but are not required to, include prior authorization on drugs. You must provide an active URL that directly links to the required information without preconditions or additional steps.
Communicating a reason for denial of a prior authorization request	45 CFR 156.223 (a)	January 1, 2026	As of no later than plan years beginning on or after January 1, 2026, does the issuer provide a specific reason for denial in responses to providers whose prior authorization requests have been denied, as required per § 156.223(a)?

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.[51] Issuers will be required to report for the 2027 plan year new or modified elements. Modified elements will include issuer- and plan-level claims received, denied, and resubmitted broken out not just by in- and out-of-network status, but also by whether claims were for behavioral health or non-behavioral-health services. New elements will include questions regarding the processing and coverage determinations for pre-service benefit requests (e.g., prior authorization requests) at the issuer level, as well as plan-level reasons for denial categories for out-of-network claims that mirror the current plan-level reasons for denial categories appliable to in-network claims. Issuers must provide both their Transparency in Coverage data and their Transparency in Coverage URL submissions via the MPMS module in HIOS. CMS is continuing to explore other ways to enhance the accuracy of these data, including whether to use these data for compliance purposes in future plan years.

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

(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 2026. Please refer to the 2018 through 2026 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For the 2027 plan year, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 31.476 percentage point increase in the Consumer Price Index (CPI) for dental services of 602.596 for 2025 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $110.17 to a total of $460.17. 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 2027 plan year will be $450 for one child and $900 for two or more children. For more information on how this limitation is determined, please refer to § 156.150 and to the 2018 Letter to Issuers.

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[51] *See* CMS-10572, "Information Collection for Transparency in Coverage Reporting by Qualified Health Plan Issuers," (OMB Control Number 0938-1310).

Section 2. SADP Actuarial Value (AV) Requirements

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

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

Section 3. SADP Age on Effective Date Methodology Requirement

Guidance on the requirement for SADP issuers to use an enrollee's age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee's age for rating and eligibility purposes remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

Section 4. SADP Guaranteed Rates Requirement

Guidance on the requirement for SADP issuers to submit guaranteed rates remains unchanged from 2024. Please refer to the 2024 Letter to Issuers for more information.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

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

Guidance on QHP issuer account management, issuer compliance monitoring, issuer compliance reviews, and issuer participation for the full plan year generally remains unchanged from 2018 and later years. Please refer to the 2018 through 2026 Letters to Issuers for more information.

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

The approach for 2027 remains unchanged from 2024. Please refer to the 2018 through 2026 Letters to Issuers for more information.

CMS intends to continue to work with States as well as QHP issuers to monitor the activities of agents and brokers participating in the FFEs and SBE-FPs, and prevent fraud, waste, and abuse.

Section 2. FFE Oversight of Agents and Brokers

The approach for 2027 remains largely unchanged from 2026, with the exception that CMS has proposed expanded regulations on agent, broker, and web-broker misleading marketing practices in the proposed 2027 Payment Notice. Please refer to the 2018 through 2026 Letters to Issuers for more information.

i. Monitoring and Oversight

Agents, brokers, and web-brokers must comply with agreements with CMS under 45 CFR 155.220(d) in order to enroll consumers in QHPs or to assist them in applying for APTCs and cost-sharing reductions through the Exchanges.[52] The FFE Agreements require registration with CMS, completion of training, and compliance with standards of conduct and other CMS requirements. If the agent, broker, or web-broker does not have active FFE agreements for the plan year because CMS terminated them in accordance with § 155.220(g), then the agent, broker, or web-broker is no longer registered with the FFE and may not assist individuals with Exchange enrollments or applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs through the Exchanges.

CMS' view is that QHP issuers are not required by CMS regulations to pay compensation to agents, brokers or web-brokers while their FFE Agreements are either suspended or terminated.

However, it is CMS' position that if CMS subsequently rescinds an agent's, broker's, or web-broker's suspension or termination *back to the initial date of the suspension or termination*, the suspensions and terminations are no longer grounds for issuers to not compensate the agent, broker, or web-broker for enrollments through the Exchanges while the suspension and/or termination of the agent, broker, or web-broker's FFE Agreements were active. CMS' view is that issuers may compensate the agent, broker, or web-broker for enrollments during that time without violating CMS rules, in situations where CMS has subsequently rescinded the suspensions or terminations from the beginning.

Additionally, in July 2025, CMS updated the Agent and Broker FFE Registration Termination List (RTL)[53] by adding reason codes to provide greater transparency regarding agent and broker enforcement actions taken by CMS. Each reason code consists of a two-character alphanumeric identifier: the first character is either "R" (for registered status) or "T" (for terminated status), while the second numeric character specifies the reason for the compliance action. These codes also include detailed information about the nature of the violation, including whether it occurred in the agent's, broker's, or web-broker's resident State or a non-resident State. These changes are designed to provide issuers and State Departments of Insurance with improved transparency.

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[52] Agents, brokers, and web-brokers enter into General Agreements and Privacy and Security Agreements with CMS. Entities that wish to participate in the Small Business Health Options Program (SHOP) also enter into SHOP Agreements. These are referred to collectively herein as "FFE Agreements."

[53] Issuers may view the RTL at https://data.healthcare.gov/ab-suspension-and-termination-list.

For additional guidance on QHP issuer oversight of agents and brokers as it relates to compensation, please refer to the 2016 Letter to Issuers, 2017 Letter to Issuers, 2018 Letter to Issuers, and 2026 Letter to Issuers.

ii. Misleading Marketing

CMS determined that advertisements made by agents, brokers, and web-brokers on social media marketing their services related to Exchange enrollments may contain false or misleading information meant to mislead or coerce a consumer into enrolling in a QHP without full knowledge or consent and/or providing their personally identifiable information to an agent, broker, or web-broker under false pretense.

Current regulations state that agents, brokers, and web-brokers may not engage in marketing "…that is misleading, coercive, or discriminatory…" In the proposed 2027 Payment Notice, CMS proposed to expand the regulatory text at § 155.220(j)(3) to list seven specific prohibited marketing practices to help reduce consumer harm by preventing these types of advertisements from being posted. These seven non-exhaustive prohibited practices are: (1) Providing cash, rebates, gift cards, travel vouchers, or other incentives to induce enrollment; (2) Providing gifts that are more than nominal in value; (3) Guaranteeing $0 coverage; (4) Using government logos; (5) Misstating enrollment timelines and deadlines; (6) Misstating legislation, regulations, or Executive Orders; and (7) Falsely using the name, image, or likeness of public figures as endorsement. If finalized as proposed, the expanded list would provide agents, brokers, and web-brokers with a clearer understanding of the marketing requirements and help ensure they are afforded adequate due process. The proposed regulations at § 155.220(j)(3) would also require agents, brokers, and web-brokers to submit marketing materials to CMS upon request during an investigation. Further, the expanded text would remind agents, brokers, and web-brokers that they are responsible for any marketing-related content posted by a downstream entity with whom they work or are associated. Please refer to the proposed 2027 Payment Notice for more information about these changes.

CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

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

Section 1. Coverage Appeals

The approach to coverage appeals generally remains unchanged from the 2023 Letter to Issuers and later years with the exception of the following update: The Departments of Labor, HHS, and the Treasury (the Departments) have issued updated and newly translated materials consistent with the Departments' 2023 County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) Guidance.[54] That guidance identifies the applicable non-English languages

[54] County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) (November 2023), *available at*: https://www.cms.gov/files/document/clas-county-data-2023.pdf; *see also* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), *available at*: https://www.cms.gov/files/document/faqs-part-63.pdf and https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63.

in which plans and issuers must provide internal claims and appeals and external review notices in a culturally and linguistically appropriate manner, in accordance with the rules implementing section 2719 of the PHS Act.[55] The updated internal claims and appeals and external review model notices include four additional taglines in Pennsylvania Dutch, Samoan, Carolinian and Chamorro and can be found here: https://www.cms.gov/marketplace/resources/forms-reports-other#External_Appeals.

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

The approach to meaningful access generally remains unchanged from the 2025 Letter to Issuers and later years with the exception of the following update. The Departments have issued updated and newly translated materials consistent with the Departments' 2023 County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) Guidance.[56] That guidance identifies the applicable non-English languages in which plans and issuers must provide internal claims and appeals and external review notices, as well as the SBC and uniform glossary, in a culturally and linguistically appropriate manner, in accordance with the rules implementing sections 2719 and 2715 of the PHS Act, respectively.[57] The updated internal claims and appeal and external review model notices can be found here: https://www.cms.gov/marketplace/resources/forms-reports-other#External_Appeals and the updated SBC materials which include four new taglines in Pennsylvania Dutch, Samoan, Carolinian, and Chamorro and new translations in those same languages can be found here: https://www.cms.gov/marketplace/resources/forms-reports-other#Summary_of_Benefits_and_Coverage_and_Uniform_Glossary. https://www.cms.gov/marketplace/resources/forms-reports-other#External_Appeals.

Section 4. Summary of Benefits and Coverage (SBC)

The guidance on the SBC largely remains unchanged from the 2025 Letter to Issuers, with the exception of the following update and reminders.

The Departments have issued new translated materials consistent with the Departments' 2023 County Data for Culturally and Linguistically Appropriate Services (CLAS County Data)

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[55] *See* 26 CFR 54.9815-2719(e), 29 CFR 2590.715-2719(e) and 45 CFR 147.136(e). Similar rules apply for the Summary of Benefits and Coverage under 26 CFR 54.9815-2715(a)(5), 29 CFR 2590.715-2715(a)52), and 45 CFR 147.200(a)(5).

[56] County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) (November 2023), available at: https://www.cms.gov/files/document/clas-county-data-2023.pdf; *see also* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), available at: https://www.cms.gov/files/document/faqs-part-63.pdf and https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63.

[57] *See* 26 CFR 54.9815-2719(e), 29 CFR 2590.715-2719(e) and 45 CFR 147.136(e) and 26 CFR 54.9815-2715(a)(5), 29 CFR 2590.715-2715(a)52), and 45 CFR 147.200(a)(5).

Guidance.[58] That guidance identifies the applicable non-English languages in which plans and issuers must provide the SBC and uniform glossary in a culturally and linguistically appropriate manner, in accordance with the rules implementing section 2715 of the PHS Act.[59] The updated SBC materials, which include four new taglines in Pennsylvania Dutch, Samoan, Carolinian, and Chamorro and new translated materials in those same languages, can be found here: https://www.cms.gov/marketplace/resources/forms-reports-other#Summary_of_Benefits_and_Coverage_and_Uniform_Glossary.

As a reminder, SBCs must accurately represent an enrollee's anticipated cost sharing.[60] American Indian/Alaska Native (AI/AN) enrollees are entitled to unique benefits, including zero cost-sharing, when receiving care from non-Indian Health Care Providers (IHCP) for enrollees in a zero cost-sharing plan variation. Also, zero cost-sharing is incurred when receiving care from non-IHCPs with IHCP referrals for enrollees in a limited cost-sharing plan variation. To accurately represent cost-sharing information on SBCs prepared for limited cost-sharing plan variations, we encourage issuers to clearly indicate that cost sharing is waived for non-IHCP visits with a referral from an IHCP. One way to represent this—as shown in the sample completed SBC for limited cost-sharing plans[61]—is by providing relevant language in the *Limitations, Exceptions, & Other Important Information* column for each applicable service. We also encourage issuers to refer to the sample completed SBCs for both the limited cost-sharing and zero cost-sharing plans which provide an instructive example for how to complete SBCs for those plan variations. As an additional reminder, QHP issuers must also include a box below the coverage examples with the following language: "Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher."

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.[62]

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[58] County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) (November 2023), *available at*: https://www.cms.gov/files/document/clas-county-data-2023.pdf; *see also* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), *available at*: https://www.cms.gov/files/document/faqs-part-63.pdf and https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63.

[59] *See* 26 CFR 54.9815-2715(a)(5), 29 CFR 2590.715-2715(a)52) and 45 CFR 147.200(a)(5).

[60] *See* Section 2715(b) of the PHS Act; 26 CFR 54.9815-2715(a)(2), 29 CFR 2590.715-2715(a)(2) and 45 CFR 147.200(a)(2).

[61] *See* Sample Completed AI/AN Limited Cost Sharing SBC, *available at*: https://www.cms.gov/files/document/english-aian-limited-cost-sharing-sbc-accessible-format-012825.pdf.

[62] *See* model QHP Addendum for Indian health providers, *available at*: https://www.qhpcertification.cms.gov/s/Model_QHP_Addendum_Indian_Health_Care_Providers.pdf?v=1.