Department of Health & Human Services

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

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From: Center for Consumer Information and Insurance Oversight (CCIIO),

Centers for Medicare & Medicaid Services (CMS)

Title: 2020 Draft Letter to Issuers in the Federally-facilitated Exchanges

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2020 Draft Letter to Issuers in the Federally-facilitated Exchanges (2020 Draft Letter). This Letter provides updates on operational and technical guidance for the 2020 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). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2020. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2020 Draft Letter focuses on guidance that has been updated for the 2020 plan year, and refers issuers to the 2018 Letter to Issuers in the Federally-facilitated Exchanges (2018 Letter to Issuers) or 2019 Letter to Issuers in the Federally-facilitated Exchanges (2019 Letter to Issuers) in all instances where CMS guidance has not changed.[1] CMS notes that the policies articulated in this Letter apply to the certification process for plan years beginning in 2020.[2]

Throughout this 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. CMS also describes how parts of this Letter apply to issuers in State-based Exchanges on the Federal platform (SBE-FPs).

Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics are set out in 45 CFR Subtitle A,

[1] Center for Consumer Information and Insurance Oversight, CMS, 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 (April 9, 2018), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf.

[2] Plan years in the FF-SHOPs will not always align with calendar year 2020.

Subchapter B. Unless otherwise indicated, regulatory references in this Letter are to Title 45 of the Code of Federal Regulations (CFR). CMS proposed additional standards in the proposed rule titled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; Proposed Rule," CMS 9926-P (2020 Payment Notice Proposed Rule) which displayed on January 17, 2019. While certain parts of the Draft Letter explain associated regulatory requirements, the 2020 Draft Letter is not a complete list of regulatory requirements for issuers.

CMS welcomes comments on this proposed guidance. To the extent that this guidance summarizes policies proposed through other rulemaking processes that have not yet been finalized, such as the rulemaking process for the 2020 Payment Notice Proposed Rule, stakeholders should comment on those underlying policies through the ongoing rulemaking processes, and not through the comment process for this Letter. Please send comments on other aspects of this Letter to FFEcomments@cms.hhs.gov by **February 19, 2019**. Comments will be most helpful if organized by subsections of this Letter.

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

The Patient Protection and Affordable Care Act (PPACA) 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 markets, both inside and outside of the Exchanges. The remaining standards are specific to health plans seeking QHP certification from the Exchanges.

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

Section 1. QHP Certification Process and Timeline

As in prior years, issuers will submit a complete QHP application for all plan year 2020 plans they intend to have certified in a state in which an FFE is operating. Through an iterative process as shown in Table 1.1, CMS will review QHP applications for current and new issuers applying for QHP certification in an FFE[4] and send issuers notices summarizing any need for corrections after each round of review. After the final correction notice is sent, CMS will conduct outreach to issuers with CMS or state identified data errors, and then issuers will submit corrections during the limited data correction window submission dates in Table 1.1. An issuer must submit a plan withdrawal form to CMS to withdraw a plan from QHP certification consideration, or to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration. As reflected in Table 1.1, with the final correction notice CMS will also post a list of plans received and reviewed during the QHP application process in each issuer's profile in the CCIIO Plan Management Community (PM Community). Each issuer will

[3] SBE-FPs should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this Letter.

[4] 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.

access such list and confirm their plans within the PM Community. An issuer's submission of the final plan confirmation list to CMS is generally the last opportunity for such issuer to withdraw a plan from certification consideration for the upcoming plan year.

Finally, issuers intending to offer QHPs, including SADPs, in the FFEs, including issuers in states performing plan management functions, will sign and submit to CMS a QHP Certification Agreement and Privacy and Security Agreement (the "QHP Certification Agreement") and a Senior Officer Acknowledgement.[5] 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, including providing information about the plans to FFE registered agents and brokers.

Table 1.1 lists key plan year 2020 dates for QHP certification applications. Issuers may have their QHP application denied if they fail to meet the deadlines in Table 1.1 or their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.[6]

New for plan year 2020, Table 1.1 includes key dates for an "Early Bird" QHP Application submission window, Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey), Transparency in Coverage data submissions, and Machine Readable file posting. Additional information about each requirement is found in Chapter 2, Section 7 (Quality Reporting), Chapter 3, Section 2 (Transparency in Coverage) and Chapter 3, Section 1 (Consumer Support Tools), respectively. The "Early Bird" QHP Application submission window is an optional submission window for issuers wishing to submit application data prior to the first formal submission deadline. CMS will review and return results on this data as available prior to the first submission deadline, and if the identified corrections are corrected, CMS will not flag it as a correction in the full review round and the issuer will not receive a correction notice. Table 1.1. Timeline for QHP Certification in the FFEs[7]

Activity	**Dates**
Initial QHP Application submission window	4/25/19-6/19/19
Optional Early Bird QHP Application submission deadline	5/22/19
2019 QHP Enrollee survey data submission deadline	5/24/19

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

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

[7] All dates are subject to change.

Activity	Dates
CMS reviews Early Bird QHP Application data as of 5/22/19 and releases results	5/23/19-6/11/19
2019 QRS clinical data submission deadline	6/17/19
Initial QHP Application deadline	6/19/19
Initial deadline for QHP Application Rates Table Template	7/24/19
CMS reviews initial QHP Applications as of 6/19/19	6/20/19-8/2/19
CMS releases first correction notice	8/9/19
Service area data change request deadline	8/12/19
Issuers complete final plan confirmation in the PM Community	8/14/19-8/28/19
Deadline for issuers to change QHP Application	8/21/19
Transparency in Coverage data submission deadline	8/29/19[8]
CMS reviews QHP Applications as of 8/21/19	8/22/19-9/9/19
CMS sends QHP Certification Agreements	9/16/19
CMS releases final correction notice	9/16/19
Limited data correction window	9/19/19-9/20/19
Issuers return signed agreements and final plan crosswalks to CMS	9/16/19-9/24/19
States send CMS final plan recommendations	9/16/19-9/24/19
Machine Readable file posting deadline	9/27/19
CMS releases certification notice to issuers and states	10/3/19-10/4/19
Open Enrollment begins	11/1/19

Section 2. QHP Application Data Submission

CMS expects issuers to adhere to the QHP certification timeline. CMS requires issuers, including SADP issuers, to submit complete QHP applications by the initial submission deadline on June 19, 2019,[9] and to make necessary updates to the QHP application prior to the last deadline for issuer submission on August 21, 2019. Additionally, issuers in direct enforcement states must comply with any CMS requirements related to form and rate filings, in addition to any applicable state requirements.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.[10] All issuers must also register for the PM Community to receive correction and

[8] Submission date is subject to change pending PRA approval.
[9] Initial deadline for the QHP Rates Table Template only is July 24, 2019.
[10] Additional information on HIOS registration is available in the HIOS Portal User Manual, available at: https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Content Requirements for Plan Finder. CMS expects issuers to use the same HIOS plan identification numbers for plans submitted for certification for plan year 2020 that are the same plans certified as QHPs, including SADPs, for plan year 2019, as defined in 45 CFR 144.103 and pursuant to 45 CFR 147.106. While 45 CFR 147.106 is not applicable to issuers of SADPs, CMS expects SADP issuers to use the same HIOS plan identification numbers for plans submitted for certification for plan year 2020 as SADPs for plan year 2019 that have been modified, to the extent the

certification notices, as well as other relevant communications regarding their QHP applications.[11]

Issuers applying for QHP certification in FFEs, excluding those in states performing plan management functions, must submit their QHP applications in HIOS. While some FFE states use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates, any data submitted by issuers applying for QHP certification in FFEs where the state does not perform plan management functions into SERFF will not be transferred to CMS and must be submitted in HIOS. Issuers in states performing plan management functions, however, should submit QHP applications in SERFF in accordance with state and CMS review deadlines. In FFEs where the state performs plan management functions, issuers should work directly with the state to submit all QHP issuer application data in accordance with state guidance.[12] For all states, issuers seeking to offer QHPs must also submit the Unified Rate Review Template (URRT) to CMS via the Unified Rate Review module in HIOS.

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

Discrepancies between an issuer's QHP application and approved state filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP. All issuers must complete quality assurance activities to ensure the completeness and accuracy of QHP application data, including reviewing plan data in the Plan Preview environment.

Section 3. QHP Data Changes

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modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value. The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to §155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for plan year 2020 that had been certified for plan year 2019, it is subject to the standards outlined in 45 CFR 156.290.

[11] CMS will make instructions available in spring 2019 on how to enroll to receive information for the plan year 2020 QHP application period for issuers not currently participating in the PM Community.

[12] 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.

During the certification process for plan year 2020, CMS will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that CMS identified during its review of QHP applications.

Table 1.2. Key Dates for QHP Data Changes in the FFEs[13]

Activity	Dates
Initial application submission	4/25/19-6/19/19
QHP review and modification	6/20/19-8/21/19
Data changes after QHP application deadline	8/22/19-10/4/19
After final data submission	10/5/19-onward

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 both on and off-Exchange. Issuers also may not change plan type(s) or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan. Issuers may only change their service area after CMS approves the change. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to state or CMS feedback until the deadline for issuer changes. For all other changes, issuers are also not required to submit data change requests or document state authorization to CMS. CMS will monitor all data changes and contact issuers if there are concerns about changes made.

To withdraw a plan from QHP certification consideration, an issuer must submit to CMS a plan withdrawal form. 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 August 21, 2019, deadline for issuer changes to QHP applications, issuers will only make corrections directed by CMS or by their state. States may direct changes by contacting CMS with a list of required corrections. Issuers whose applications are not accurate after the August 21, 2019, deadline for issuer submission of changes to the QHP application, and are then required to resubmit corrected data during the limited data correction window, may be subject to

[13] All dates are subject to change.

compliance action by CMS. Issuer changes made in the limited data correction window not approved by CMS and/or the state may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After completion of the QHP certification process, CMS may offer additional data correction windows. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the state or CMS. CMS will offer windows for SHOP quarterly rate updates. A request for a data change after August 21, 2019, excluding administrative changes or SHOP quarterly rate updates, may be made due to inaccuracies in or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved state filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on HealthCare.gov until the data is corrected and refreshed for consumer display.

Section 4. QHP Review Coordination with States

Each state will define the relevant submission window for state-level reviews as well as dates and processes for corrections and resubmissions. CMS will rely on states' reviews of issuer-submitted policy forms and rate filings for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines.[14] States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for 2020 plan year coverage.[15]

When states perform QHP certification reviews,[16] they may exercise reasonable flexibility in their application of CMS's QHP certification standards, provided that the state's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP

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

[15] Center for Consumer Information and Insurance Oversight, CMS, Draft Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2019 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2020 *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Review of Insurance Rates.

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

certification in states that are performing plan management functions should continue to refer to state direction in addition to this guidance.

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

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

For states performing plan management functions, the SERFF data transfer deadlines will align with the HIOS submission deadlines, as was the case for plan year 2019 submissions. These state transfers should include all plans submitted to the state for certification, including SADPs for off-Exchange sale.[17] CMS understands that all state reviews might not be complete by the submission deadlines, but as stated above, requires state confirmation of approval of QHPs for sale prior to CMS certification.

All states are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to state guidelines separate from PPACA certification requirements, as early in the certification process as practicable. For CMS to ensure this information is taken into account for certification, states must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the state plan recommendation deadline in Table 1.1. CMS will provide states with detailed guidance regarding the process for submitting plan approval recommendations to CMS prior to the start of and throughout the QHP certification cycle. CMS will work with all state regulators to confirm

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

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

The approach for 2020 certification with regard to plan ID crosswalk and alternate enrollments remains unchanged from that used in 2018 for QHPs that are not SADPs. SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, CMS aims to apply the processes established for the 2020 plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for plan years beginning in 2020.

Section 6. OPM Certification of Multi-State Plan Options

The approach for 2020 U.S. Office of Personnel Management (OPM) certification of Multi-State Plan options remains unchanged from that used in 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 7. Issuer Participation for the Full Plan Year

The approach for 2020 remains unchanged from that used in 2018. Please refer to the 2018 Letter to Issuers for more information.

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

This Chapter provides an overview of key QHP certification standards for both QHPs and SADPs in FFEs, including those in states performing plan management functions, and how CMS or the state will evaluate and conduct reviews of 2020 QHPs and SADPs for compliance.

Section 1. Licensure and Good Standing

The approach for licensure and good standing remains unchanged from that used in 2018. Please refer to the Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later ("State Guidance on QHP Reviews") for more information.[18] 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

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

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 that used in 2018. Issuers will not be permitted to change their plans' service area after their initial data submission except via a data change request to CMS. Please refer to the 2018 Letter to Issuers for more information.

Section 3. Network Adequacy

i. Network Adequacy Standard and Certification Review

CMS will use the same approach to review network adequacy that it used for plan year 2019. Please refer to the 2019 Letter to Issuers for additional information.

ii. Provider Transitions and Out-of-Network Cost Sharing for In-Network Settings

The approach for provider transitions and out-of-network cost sharing for in-network settings remains unchanged from 2018. As a reminder, §156.230(e) instructs issuers to (1) count the cost sharing paid by an enrollee for an essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or (2) provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under state law, and that any additional charges may not count toward the in-network annual limitation on cost sharing. CMS may conduct audits to confirm consumers are being provided this information in advance of incurring charges.

iii. Network Transparency

CMS will continue testing patient use and experience on HealthCare.gov to enhance and improve the display of QHP network breadth information. Please refer to the 2018 Letter to Issuers for more information on network breadth.

For plan year 2020, CMS will utilize the same methodology used in 2019 for calculating and describing network breadth on HealthCare.gov.

Section 4. Essential Community Providers

The ECP standard and the approach for reviews of the ECP standard remain unchanged from those used in 2019. Please refer to the Patient Protection and Affordable Care Act; HHS Notice

of Benefit and Payment Parameters for 2019 (83 Fed. Reg. 16930 (Apr. 17, 2018) (2019 Payment Notice Final Rule) and the 2019 Letter to Issuers for more information.

Additionally, CMS will maintain an ongoing initiative to collect provider data directly from providers through the ECP petition process to ensure issuer access to the most up-to-date provider information.[19] CMS will continue to allow ECP write-ins for plan year 2020 to count toward the satisfaction of the ECP standard only for the issuer that writes in the ECP on its ECP template. Additionally, the issuer should arrange for the written-in provider to submit an ECP petition to HHS by no later than the deadline for issuer submission of changes to the QHP application.

Section 5. Accreditation

The approach for reviews of the accreditation standard remains unchanged from that used in 2019, with the exception noted below. Please refer to the 2019 Letter to Issuers for more information.

45 CFR 155.1045 establishes that prior to a QHP issuer's second year of QHP certification, an issuer must be accredited on the policies and procedures that are applicable to its Exchange products. CMS recognizes that some issuers may choose to pursue accreditation that includes the requirements in 45 CFR 156.275 by their second year, and that due to the required data submission, an issuer's accreditation status may be "scheduled" or "in process" 90 days prior to open enrollment. CMS will continue to apply the timeline in 45 CFR 155.1045(b) by using the issuer's accreditation status 90 days prior to open enrollment. Issuers can meet the second year requirement by submitting documentation from their accrediting entity indicating that the issuer has completed the policies and procedures review and are scheduled or in process for additional review. This does not apply to issuers entering their fourth year of QHP certification, which must still have a valid accreditation status as detailed in the 2017 Letter to Issuers.

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards is unchanged from the 2017 Letter to Issuers.[20] Please refer to that document for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds. CMS will continue to assess these standards and any related burden for issuers and hospitals.

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[19] See web-based ECP Petition for the 2020 plan year: https://data.healthcare.gov/cciio/ecp_petition.
[20] 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-2-29-16.pdf.

Section 7. Quality Reporting

The approach for review of QHP issuer compliance with quality reporting standards related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey) remains unchanged from that used in 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 2019[21] for more detailed information on issuer data collection and reporting requirements for the 2019 calendar year. At this time, QRS and QHP Enrollee Survey reporting requirements do not apply to SADPs.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for QIS reporting remains unchanged from the 2018 Letter to Issuers. Please refer to the 2018 Letter to Issuers for more information. CMS will provide information on QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2020 Plan Year.

Section 9. Review of Rates

This section pertains to QHP rate filings. Additional information is available in 45 CFR Part 154.[22]

As required by 45 CFR 156.210(c) and 155.1020, a QHP issuer must submit a rate filing justification for a rate increase prior to implementation of such an increase, and an Exchange must consider all rate increases when certifying plans as QHPs. A rate filing justification includes:[23]

(1) Unified Rate Review Template (URRT) (Part I), required for all single risk pool products, including new and discontinuing products;

[21] Center for Clinical Standards & Quality, CMS, The Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019 (Oct. 2018), *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

[22] CMS does not plan to duplicate reviews by states to enforce state law, and will integrate state and other rate reviews performed by CMS for states without an Effective Rate Review Program into its QHP certification process, provided that states provide information to CMS consistent with federal standards and agreed-upon timelines. CMS will post the information contained in Parts I, II, and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information, consistent with HHS Freedom of Information Act (FOIA) regulations. The information will be posted on https://ratereview.healthcare.gov/.

[23] 45 CFR 154.215.

(2) URRT (Part I) and Actuarial Memorandum (Part III), required for each single risk pool product that includes a plan that is subject to a rate increase, regardless of the size of the increase;[24] and/or

(3) URRT (Part I), written description justifying the rate increase (also known as a Consumer Justification Narrative) (Part II), and Actuarial Memorandum (Part III), required for each single risk pool product that includes a plan with a rate increase that is subject to review under 45 CFR 154.200.

The reasonableness review federal default threshold remains at 15 percent for the 2020 plan year. Therefore, QHP issuers must submit Part II of the rate filing justification for each single risk pool product that includes a plan with a rate increase of 15 percent or more or other applicable state-specific threshold.[25]

Section 10. Discriminatory Benefit Design

The approach to discriminatory benefit design remains unchanged from that used in 2018. Please refer to the 2018 Letter to Issuers for more information regarding discriminatory benefit design, QHP discriminatory benefit design, and the treatment protocol calculator.

As noted in the State Guidance on QHP Reviews,[26] CMS does not conduct active certification reviews for cost sharing outliers for states that perform plan management functions, and instead defers to those state processes. CMS will continue to review for cost sharing outliers in FFE states that do not perform plan management functions.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from that used in 2018. In response to the ongoing nationwide public health emergency,[27] opioid use disorder was added as a condition to the clinical appropriateness review in 2019 and will

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[24] Issuers may also submit a redacted version of the Actuarial Memorandum if their Actuarial Memorandum contains trade secrets or confidential commercial or financial information consistent with HHS's FOIA regulations. See instructions at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions_for_the_Redacted_Actuarial_Memorandum_20150416.pdf.

[25] States have flexibility to establish a different threshold for review. See 45 CFR 154.200(a)(2).

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

[27] Renewal of determination that a public health emergency exists as a result of opioid crisis. https://www.phe.gov/emergency/news/healthactions/phe/Pages/mariana-yutu-25Oct2018.aspx.

continued to be used during plan year 2020 reviews. Please refer to the 2018 Letter to Issuers for more information.

Additionally, as noted in the State Guidance on QHP Reviews, CMS does not conduct active certification reviews for formulary outliers for states that perform plan management functions, and instead defers to those state processes. CMS will continue to review for formulary outliers in FFE states that do not perform plan management functions.

Section 12. Third Party Payment of Premiums and Cost Sharing

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

Section 13. Cost-sharing Reduction Plan Variations

The approach for cost-sharing reductions provided by issuers to consumers remains unchanged from that used in 2018. Please refer to the 2018 Letter to Issuers for more information. Eligible consumers can enroll in these plan variations for the 2020 plan year and will continue to receive cost-sharing reductions provided by the issuers. However, cost-sharing reduction payments to issuers cannot be made in the absence of an appropriation.

Note that in reviewing cost sharing reduction plan variations for compliance with 45 CFR 156.420, CMS proposes in the 2020 Payment Notice Proposed Rule to apply different annual limits on cost sharing than those outlined in the 2018 Letter to Issuers. This proposal is meant to ensure that silver plan variations have an annual limitation on cost sharing that does not exceed the permissible threshold for the specified plan variation.

Section 14. Data Integrity Review

The approach for conducting data integrity reviews remains unchanged from that used in 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 15. Ensuring Consumer Access to Qualified Health Plans without Non-Hyde Abortion Coverage

In the 2020 Payment Notice Proposed Rule, CMS proposed that QHP issuers that elect to offer coverage for non-Hyde abortion services in QHPs offered on the individual market Exchanges must also offer a plan that does not offer non-Hyde abortion coverage but is otherwise equivalent to one of the plans that does, beginning with plan year 2020. Specifically, at §156.280(c)(2)(i), CMS proposed that, beginning with plan year 2020, if a QHP issuer provides coverage of non-Hyde abortion services in one or more QHPs, at any coverage level as described in §156.140, the QHP issuer must also offer throughout each service area in the Exchange in which it offers such

coverage at least one QHP that omits coverage of non-Hyde abortion services but otherwise mirrors one of the QHPs that provides that coverage. The QHP issuer would only be required to offer at least one "mirror QHP" in each service area that the QHP issuer offers plans covering non-Hyde abortion coverage, even if the issuer has multiple plans that offer non-Hyde abortion services in a single service area. Under this proposal, the QHP issuer would determine at which metal level the mirror plan is offered.

If the 2020 Payment Notice Proposed Rule is finalized as proposed, the FFEs would apply this certification standard by ensuring that QHP issuers that offer non-Hyde abortion coverage in QHPs also offer throughout each service area in the Exchange in which it offers such coverage at least one "mirror QHP" that omits coverage of such services. The proposed certification standard under §156.280(c)(2)(i) would not apply to SADPs. This requirement would apply to the extent permissible under state law.

CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION

Section 1. Consumer Support Tools

CMS has 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, including through an FF-SHOP. Please see the 2018 Letter to Issuers for more information on these features, including provider and formulary search functions and the out-of-pocket cost comparison tool.

Section 2. Transparency in Coverage Reporting

The content of this section outlines proposed transparency reporting requirements for all QHP issuers, including SADP issuers, in the FFEs, including in states that are performing plan management functions. The data submission deadline is August 29, 2019, and is subject to change pending PRA approval. We intend to align with the QHP submission process beginning in plan year 2021.

Pursuant to 45 CFR 155.1040(a)-(c) and 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection, CMS-10572, "Transparency in Coverage Reporting by Qualified Health Plan Issuers," Paperwork Reduction Act (PRA) Package to OMB for an additional 3-year collection period, and it is available for 60-day public comment through December 24, 2018. CMS encourages interested parties to comment on the PRA package via the PRA comment process. The data collection elements that QHP issuers reported from 2016 to 2019 may change for purposes of transparency reporting for 2020. We will provide instructions regarding the transparency in coverage reporting requirements for the 2020 plan year in future guidance, following considerations of comments on the PRA package

To reduce issuer burden, CMS proposed as part of the PRA package integrating the transparency reporting process into the QHP certification process, such that issuers would submit the transparency template in the same manner as other QHP certification templates beginning with the 2021 plan year.

CHAPTER 4: STAND-ALONE DENTAL PLANS: 2020 APPROACH

The approach for submitting applications for certification of QHP SADPs remains unchanged from that used in 2019. Please refer to the 2018 and 2019 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For plan year 2020, the SADP annual limitation on cost sharing for one covered child is $350 increased by the percent increase of the Consumer Price Index (CPI) for dental services for 2018 over the CPI for dental services for 2016. The applicable percentage increase in the CPI for dental services for 2018 over the CPI for dental services for 2016 is 3.685 percent (approximately 2.137 percent from 2016 to 2017 and 1.548 percent from 2017 to 2018), which would cumulatively increase the annual limitation on cost-sharing for SADPs by $12.90 ($350 X 0.03685). Because this amount is less than $25, and the regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of $25, the annual limitation on cost sharing for SADPs for plan year 2020 will remain $350 for one child and $700 for two or more children. For more information on how this limitation is determined, please refer to the regulation and to the 2018 Letter to Issuers.

Section 2. SADP Actuarial Value Requirements

The approach to actuarial value requirements and certification for SADP coverage of the pediatric EHB remains largely unchanged from that used in 2019. For plan year 2020, SADP issuers may offer the pediatric dental EHB at any actuarial value. SADP issuers will be required to certify the actuarial value of each SADP's coverage of pediatric dental EHB.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

Section 1. FFE Oversight of QHP Issuers and Web-brokers Using a Direct Enrollment Pathway

Guidance on QHP issuer account management, issuer compliance monitoring, issuer compliance reviews, FFE oversight of agents and brokers, and issuer participation for the full plan year remains unchanged from 2018. Please refer to Chapter 5 of the 2018 Letter to Issuers for more information.

i. Oversight Mechanisms

In the 2020 Payment Notice Proposed Rule, CMS proposed several changes to FFE oversight mechanisms for direct enrollment (DE) entities (QHP issuers and web-brokers participating in direct enrollment). QHP issuers and web-brokers participating in direct enrollment for plan years beginning in 2020 should review the 2020 Payment Notice Proposed Rule for details on these proposals and the final rule when it is promulgated. CMS will provide further guidance about FFE oversight of DE entities, as necessary, after the 2020 Payment Notice Final Rule is promulgated.

ii. Standards for Direct Enrollment Entities and for Third-Parties to Perform Audits of Direct Enrollment Entities

In the 2019 Payment Notice Final Rule, CMS made changes to audit standards for DE entities. In the 2020 Payment Notice Proposed Rule, CMS proposed further changes to standards for DE entities and for third-parties to perform audits of DE entities. DE entities and third-party auditors should review the 2020 Payment Notice Proposed Rule for details on these proposals. CMS will provide further guidance about standards for DE entities and for third-parties performing audits of DE entities, as necessary, after the 2020 Payment Notice Final Rule is promulgated.

Section 2. FFE Oversight of Agents and Brokers

The approach regarding oversight of agents and brokers remains unchanged from 2018 but also applies to web-broker DE entities. In addition, QHP issuers and web-brokers participating in direct enrollment must confirm all affiliated or downstream agents' and brokers' licensure statuses, and verify fulfillment of the FFE registration, applicable training requirements and execution of applicable agreements before allowing access to the QHP issuer's or web broker's tools to assist with enrollment through the FFEs and/or providing compensation for Exchange transactions. QHP issuers and web-brokers must verify agents' and brokers' FFE registration status for the applicable plan year by visiting the CMS agent and broker resources page and linking to the Registration Status Lists (Registration Completion List (RCL) and Registration Termination List (RTL)) available on Data.HealthCare.Gov.

CHAPTER 6: FF-SHOPS

In the 2019 Payment Notice Final Rule, CMS finalized substantial changes to how the FF-SHOPs will operate. Issuers applying for certification of plans as QHPs to be offered through FF-SHOPs should review the 2019 Payment Notice Final Rule.

CHAPTER 7: CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Consumer Case Tracking and Coverage Appeals

The approaches to consumer case tracking and coverage appeals remain unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 2. Meaningful Access

Guidance on meaningful access remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 3. Summary of Benefits and Coverage

Guidance on the Summary of Benefits and Coverage (SBC) remains unchanged from 2018. Please refer to the 2018 Letter to Issuers for additional information.

As a reminder, guidance on the SBC applies to all QHP issuers in the FFEs, but not to SADPs. Additionally, QHP issuers were required to begin using the 2017 SBC on or before the 2017 open enrollment period for the 2018 plan year, and should continue using the 2017 SBC template and associated documents for future open enrollment periods.[28]

CHAPTER 8: TRIBAL RELATIONS AND SUPPORT

CMS guidance concerning Indian health care providers remains unchanged from 2019; for more information, please refer to the 2018 Letter to Issuers.

CHAPTER 9: STATE-BASED EXCHANGES ON THE FEDERAL PLATFORM

SBE-FPs leverage existing federal assets and operations to support certain functions of their Exchange and enforce rules governing their QHP issuers. Current SBE-FPs renewed the federal platform agreement for a term of five (5) years from January 1, 2018, to January 1, 2023. Only states that are newly transitioning to the SBE-FP model for plan year 2020 would be required to execute the federal platform agreement with CMS prior to open enrollment. For more information on this agreement and its implementation, please refer to the 2018 Letter to Issuers.

The approach to the QHP issuer requirements that are applicable to, and enforceable by, SBE-FPs has not changed from that laid out in the 2019 Letter to Issuers.[29] Likewise, the approach to authorities and responsibilities for plan management functions that are applicable to SBE-FPs

[28] Center for Consumer Information and Insurance Oversight, CMS, SBC Materials and Supporting Documents (Authorized for use on and after April 1, 2017) (April 6, 2016), *available at* https://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Summary of Benefits and Coverage and Uniform Glossary.

[29] These include the two requirements under 45 CFR 155.200(f)(2) that remained after eliminating those related to network adequacy, essential community providers, and federal meaningful difference.

has not changed from that laid out in the 2019 Letter to Issuers.[30] Finally, the approach to SHOP requirements and limitations applicable to SBE-FPs and their issuers has not changed from that laid out in the 2019 Letter to Issuers.[31] Please refer to the 2019 Letter to Issuers for more information.

As proposed in the 2020 Payment Notice Proposed Rule, issuers offering QHPs through an SBE-FP will be assessed a federal user fee rate of 2.5 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE-FP.

[30] These include the SBE-FPs retaining authority and primary responsibility for plan management functions, including performing plan data review for QHP certification standards.

[31] Beginning on January 1, 2018, issuers offering QHPs for SHOP in SBE-FPs were no longer required to send enrollment/enrollment reconciliation files or meet other requirements related to the enrollment process. Additionally, new SHOP SBE-FPs were no longer recognized although existing SBE-FPs for SHOP could maintain that status.