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Centers for Medicare & Medicaid Services  
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**Date: April 9, 2018**

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

**Title: 2019 Letter to Issuers in the Federally-facilitated Exchanges**

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2019 Letter to Issuers in the Federally-facilitated Exchanges (2019 Letter). This Letter provides updates on operational and technical guidance for the 2019 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFE) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2019. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

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

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, Subchapter B. Unless otherwise indicated, regulatory references in this Letter are to Title 45 of the Code of Federal Regulations (CFR). CMS finalized additional standards in the final rule

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<sup>1</sup> 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>.

<sup>2</sup> Plan years in the FF-SHOPs will not always align with calendar year 2019.

titled, “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule,” CMS 9934-F, which went on display on April 9, 2018 (2019 Payment Notice Final Rule).<sup>3</sup> While certain parts of the Letter explain associated regulatory requirements, the Letter is not a complete list of regulatory requirements for issuers.

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<sup>3</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, (on display April 9, 2018).

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## 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).<sup>4</sup> 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 2019 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<sup>5</sup> 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 provide each issuer with a list of plans CMS received and reviewed during the QHP application process, which each issuer will confirm. An issuer's submission of the final plan

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<sup>4</sup> SBE-FPs should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this Letter.

<sup>5</sup> In accordance with 45 CFR Part 155 subpart K, CMS will review, and approve or deny, QHP applications from issuers that are applying to offer QHPs in the FFEs. CMS will not conduct QHP certification reviews of plans that are submitted for offering only outside of the FFEs, except for SADPs seeking off-Exchange certification. In the case of an FF-SHOP QHP certification, except when the QHP is decertified pursuant to 45 CFR 155.1080, the QHP certification remains in effect through the end of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified. FFEs will not display ancillary insurance products and health plans that are not QHPs (e.g., stand-alone vision plans, disability, or life insurance products). The FFEs will only offer QHPs, including SADPs.

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.<sup>6</sup> CMS will sign the QHP Certification Agreement and return it to issuers along with a final list of certified QHPs, completing the certification process for the upcoming plan year.

Table 1.1 lists key plan year 2019 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.<sup>7</sup>

Table 1.1. Timeline for QHP Certification in the FFEs<sup>8</sup>

Activity	Dates
Initial QHP application submission window	5/9/18-6/20/18
Initial QHP application deadline	6/20/18
Initial deadline for QHP application Rates Table Template	7/25/18
CMS reviews initial QHP applications as of 6/20/18	6/21/18-8/3/18
CMS releases first correction notice	8/10/18
Service area data change request deadline	8/13/18
Deadline for issuers to change QHP application	8/22/18
CMS reviews QHP applications as of 8/22/18	8/23/18-9/10/18

<sup>6</sup> 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.

<sup>7</sup> Regulations at 45 CFR 155.1000 provide Exchanges with broad discretion to certify QHPs that otherwise meet the QHP certification standards specified in Part 156, and afford Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the “interest” of qualified individuals and qualified employers.

<sup>8</sup> All dates are subject to change.

CMS posts QHP agreements and QHP plan lists	9/17/18
CMS sends final correction notice to issuers	9/17/18
Limited data correction window issuer data submission	9/20/18-9/21/18
Issuers send signed agreements, confirmed plan lists, and final plan crosswalks to CMS	9/17/18-9/25/18
State sends CMS final plan recommendations	9/25/18
CMS sends certification notice to issuers	10/4/18-10/5/18
Open enrollment begins	11/1/18

## 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 20, 2018,<sup>9</sup> and to make necessary updates to the QHP application prior to the last deadline for issuer submission on August 22, 2018. 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.<sup>10</sup> New for plan year 2019, all issuers must also register for the CCIIO Plan Management Community to receive correction and certification notices, as well as other relevant communication regarding their QHP application.<sup>11</sup>

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<sup>9</sup> Initial deadline for the QHP Rates Table Template only is July 25, 2018.

<sup>10</sup> Additional information on HIOS registration is available in the HIOS Portal User Manual, available at: <https://www.cms.gov/ccio/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 2019 that are the same plans certified as QHPs, including SADPs, for plan year 2018, 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 2019 as SADPs for plan year 2018 that have been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value. The same definition of “plan” also will apply to re-enrollment of current enrollees into the same plan, pursuant to §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 2019 that had been certified for plan year 2018, it is subject to the standards outlined in 45 CFR 156.290.

<sup>11</sup> CMS will make instructions available in spring 2018 on how to enroll to receive information for the plan year 2019 QHP application period for issuers not currently participating in the CCIIO Plan Management Community.

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.<sup>12</sup> For all FFE 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, as set forth in Chapter 5, Section 2, "QHP Issuer Compliance Monitoring," in the 2018 Letter to Issuers.

### Section 3. QHP Data Changes

During the certification process for plan year 2019, 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.

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<sup>12</sup> CMS will work with States performing plan management functions in an FFE to ensure that such guidance is consistent with Federal regulatory standards and operational timelines.



Table 1.2. Key Dates for QHP Data Changes in the FFEs<sup>13</sup>

Activity	Dates
Initial application submission	5/9/18-6/20/18
QHP review and modification	6/21/18-8/22/18
Data changes after QHP application deadline	8/23/18-10/5/18
After final data submission	10/6/18-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) 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.

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 22, 2018 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 22, 2018 deadline for issuer submission of changes to the QHP application, and are then required to enter the limited data correction window, may be subject to 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

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<sup>13</sup> All dates are subject to change.

windows for SHOP quarterly rate updates. A request for a data change after August 22, 2018, 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.<sup>14</sup> States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for 2019 plan year coverage.<sup>15</sup>

When States perform QHP certification reviews,<sup>16</sup> they may exercise reasonable flexibility in their application of CMS's QHP certification standards, provided that the State's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in States that are performing plan management functions 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

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<sup>14</sup> 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/ccio/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.

<sup>15</sup> Center for Consumer Information and Insurance Oversight, CMS, Bulletin: Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019 (April 9, 2018) available at [https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Review\\_of\\_Insurance\\_Rates](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Review_of_Insurance_Rates).

<sup>16</sup> 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.

standards. CMS notes that issuers may be required to submit data to State regulators in addition to that 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 the Exchange website. CMS will work closely with States that are 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 2018 submissions. These State transfers should include all plans submitted to the State for certification, including SADPs for off-Exchange sale.<sup>17</sup> 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 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 2019 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

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<sup>17</sup> SBE-FPs should not transfer off-Exchange SADPs.

CFR 147.106. However, CMS aims to apply the processes established for the 2019 plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for plan years beginning in 2019.

#### Section 6. OPM Certification of Multi-State Plan Options

The approach for 2019 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. Standardized Options

As noted in the 2019 Payment Notice Final Rule, we are not specifying standardized options for the 2019 plan year; therefore, CMS will not provide differential display for standardized options on HealthCare.gov in 2019.

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

The approach for 2019 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 2019 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.<sup>18</sup> As noted in the State Guidance on QHP Reviews, CMS no longer reviews issuers’ compliance with licensure and good standing standards. In FFEs, including in States performing plan management functions, States will ensure issuer compliance with 45 CFR 156.200(b)(4).

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<sup>18</sup> 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-Certification-Reviews-Guidance-41317.pdf>.

## 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*

As described in the 2019 Payment Notice Final Rule, CMS will use the same approach to review network adequacy that it used for plan year 2018 in FFEs, including in States performing plan management functions. In recognition of the traditional role States have in developing and enforcing network adequacy standards, CMS will defer to States that have a sufficient network adequacy review process. In States with the authority and means to conduct network adequacy reviews, CMS will no longer conduct these reviews. For 2019 and beyond, CMS will defer to States' reviews in States with authority to enforce standards that are at least equal to the "reasonable access standard" identified in §156.230 and means to assess issuer network adequacy. HHS also strongly encourages all issuers to consider increasing the use of telehealth services as part of their networks to ensure all consumers have access to all covered services.

In States that do not have the authority and means to conduct sufficient network adequacy reviews, CMS will apply a standard similar to the one used for the 2014 benefit year. CMS will rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. These include the three previously recognized accrediting entities for the accreditation of QHPs: the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC. Unaccredited issuers in States determined not to have authority to enforce standards that are at least equal to the "reasonable access standard" at §156.230 and means to assess issuer network adequacy would be required to submit an access plan (and cover sheet) as part of the QHP application. To show that the QHP's network meets the requirement in §156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. For plan year 2018, CMS found all States participating in FFEs to have the required network adequacy means and authority. For plan year 2019, CMS does not anticipate any changes in its assessment of States with the means and authority for network adequacy review.

### *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. Please refer to the 2018 Letter to Issuers for more information.

*iii. Network Transparency*

CMS will continue to test 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 2019, CMS will utilize the same terminology used for 2018 to describe network breadth on HealthCare.gov, but the calculation will be done for the specific county rather than for the county type (rural, urban, suburban, etc.) as done in previous years. CMS is also considering changing the data source for network breadth from certification template data, which is currently used for the analysis, to machine readable data provided by issuers starting in plan year 2020 or later.

#### Section 4. Essential Community Providers

The approach for reviews of the ECP standard remains unchanged from that used in 2018, with the exceptions noted below. Please refer to the 2018 Letter to Issuers for more information.

As described in the 2019 Payment Notice Final Rule, CMS will continue using a general ECP enforcement standard whereby the issuer will be considered to have satisfied the regulatory standard if an application demonstrates satisfaction with several criteria, which are noted in the 2018 Letter to Issuers. One criterion requires issuers to contract with a specified percentage of available ECPs in the service area. For plan year 2019, CMS will determine issuer satisfaction of the 20 percent general ECP standard applying the same calculation methodology used for plan year 2018, as indicated in the 2018 Letter to Issuers. The same applies to the alternate ECP standard and to dental ECPs. As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer will be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider network(s), as presently constituted, provides an adequate level of service for low-income and medically underserved individuals for plan year 2019 and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years. HHS encourages any such issuer to consider increasing its use of telehealth services as part of its contingency planning to ensure adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

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.<sup>19</sup> CMS will continue to allow ECP write-ins for plan year 2019 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

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<sup>19</sup> See web-based Petition for the 2019 plan year: [https://data.healthcare.gov/ccio/ecp\\_petition](https://data.healthcare.gov/ccio/ecp_petition).

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 2018, with the exceptions noted below. Please refer to the 2018 Letter to Issuers for more information.

CMS will review issuers that have previously had one or more QHPs certified to be offered through the FFE, but not for plan year 2018, and are returning to the Exchange for plan year 2019, for accreditation under the second year accreditation standard, which is found in the 2015 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.<sup>20</sup> 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.

## 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 2018<sup>21</sup> for more detailed information on issuer data collection and reporting requirements for the 2018 calendar year.

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<sup>20</sup> 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>.

<sup>21</sup> Center for Clinical Standards & Quality, CMS, The Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2018 (Oct. 2017), available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>.

## Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for QIS reporting remains unchanged from the 2018 Letter to Issuers.<sup>22</sup> 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 2019 Plan Year.

## Section 9. Review of Rates

This section pertains to QHP rate filings. Additional information is available in 45 CFR Part 154.<sup>23</sup>

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:<sup>24</sup>

- (1) URRT (Part I), required for all single risk pool products, including new and discontinuing products;
- (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;<sup>25</sup> 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.

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<sup>22</sup> As detailed in the 2019 Payment Notice Final Rule, CMS did not finalize the proposal to defer to the State in FFEs, including FFEs where the State performs plan management functions, to perform an increased role in the QHP certification reviews for QIS reporting.

<sup>23</sup> 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 direct enforcement States 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 [www.RateReview.HealthCare.gov](http://www.RateReview.HealthCare.gov).

<sup>24</sup> 45 CFR 154.215.

<sup>25</sup> 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](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions_for_the_Redacted_Actuarial_Memorandum_20150416.pdf).



In the 2019 Payment Notice Final Rule, the reasonableness review default threshold increased from 10 percent to 15 percent. 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 (rather than 10 percent or more) or other applicable State-specific threshold.<sup>26</sup>

#### 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,<sup>27</sup> CMS will not conduct active certification reviews for cost sharing outliers for States that perform plan management functions, and will instead defer 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 largely unchanged from that used in 2018, however, in response to the nationwide public health emergency,<sup>28</sup> opioid use disorder will be added as a condition to the clinical appropriateness review. Please refer to the 2018 Letter to Issuers for more information.

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

#### Section 12. Supporting Informed Patient Choice/Meaningful Difference

In the 2019 Payment Notice Final Rule, CMS removed the meaningful difference requirement as part of QHP certification. Therefore, CMS no longer requires QHP issuers to demonstrate meaningful difference and no longer conducts meaningful difference reviews.

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<sup>26</sup> States have flexibility to establish a different threshold for review. See 45 CFR 154.200(a)(2).

<sup>27</sup> 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-Certification-Reviews-Guidance-41317.pdf>.

<sup>28</sup> <https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf> and <https://www.phe.gov/emergency/news/healthactions/phe/Pages/opioid-24Jan2018.aspx>.

### Section 13. 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 14. 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 2019 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 for compliance with 45 CFR 156.420, CMS will ensure that silver plan variations have an annual limitation on cost sharing that does not exceed the permissible threshold for the specified plan variation as finalized in the 2019 Payment Notice final rule, and not the 2018 figures noted in the 2018 Letter to Issuers.

### Section 15. 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.

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

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, the out-of-pocket cost comparison tool, and transparency in coverage reporting.

More information on submission requirements for data related to transparency in coverage is also available in the 2018 Letter to Issuers. Like in 2018, CMS plans to release instructions and a submission template in late spring for 2019, which will mirror last year's data collection process.<sup>29</sup>

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<sup>29</sup> Center for Consumer Information and Insurance Oversight, CMS, Transparency in Coverage Reporting by QHP Issuers Transparency Issuer Instructions and Transparency Data Submission Template for plan year 2018 (2017), available at: <https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage>.

## **CHAPTER 4: STAND-ALONE DENTAL PLANS: 2019 APPROACH**

The approach for submitting applications for certification of QHP SADPs remains unchanged from that used in 2018, with the exceptions noted below. Please refer to the 2018 Letter to Issuers for more information.

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

The applicable percentage increase (approximately 2.137 percent from 2016 to 2017) in the Consumer Price Index (CPI) for dental services would increase the annual limitation on cost-sharing for SADPs by \$7.48. 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 2019 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**

In the 2019 Payment Notice Final Rule, we removed the requirement for SADP issuers to meet the low (70 percent +/- 2 percentage points) or high (85 percent +/- 2 percentage points) actuarial value (AV) level specified in 45 CFR 156.150(b). For plan year 2019, SADP issuers may offer the pediatric dental essential health benefit (EHB) at any actuarial value. SADP issuers will be required to certify the actuarial value of each SADP's coverage of pediatric dental EHB. SADP issuers should refer to the 2019 Qualified Health Plan Issuer Application Instructions for direction on reporting such certification to CMS.

## **CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT**

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. The guidance below provides updates to differential display of standardized options and FFE oversight of direct enrollment (DE) entities.

### **Section 1. Differential Display of Standardized Options**

In the 2019 Payment Notice Final Rule, we are not specifying any standardized options for 2019. Therefore, web-brokers<sup>30</sup> are not required to differentially display standardized options.

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<sup>30</sup> CMS uses the term “web-broker” to refer to agents or brokers who use their own website, or that of another agent or broker, to facilitate enrollment in a QHP through the FFEs or SBE-FPs in accordance with 45 CFR 155.220(c)(3)–(4).

## Section 2. FFE Oversight of QHP Issuers and Web-brokers Using a Direct Enrollment Pathway

This section describes how CMS will approach oversight of DE entities -- both QHP issuers and web-brokers -- participating in direct enrollment.

### *i. Oversight Mechanisms*

As in prior years, CMS will continue to work with States to coordinate oversight activities related to DE entities.

Pursuant to 45 CFR 155.220(c)(3), 156.265(b), and 156.1230, DE entities must comply with applicable requirements, including demonstrating operational readiness to use a DE pathway. CMS may immediately suspend the DE entity's ability to transact information with the FFEs if CMS discovers circumstances that pose unacceptable or unmitigated risk to FFE operations or FFE information technology systems.

CMS considers auditors to be downstream and delegated entities of DE entities in accordance with 45 CFR 156.340 and the QHP Issuer Agreement for QHP issuers, and in accordance with the Web-broker Agreement for web-brokers. DE entities are responsible for auditor performance and for compliance with applicable program requirements. CMS will conduct ongoing oversight of DE entities consistent with previous plan years, including regular oversight of the entity's applications in its production and testing environments for completeness and accuracy. CMS expects that DE entities will maintain accurate testing environments that accurately represent their production environment and DE pathway, as applicable.

### *ii. Standards for Third-party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment*

In the 2019 Payment Notice Final Rule, CMS made changes to 45 CFR 155.221 to permit DE entities to select their own third-party entity to conduct operational readiness reviews for agents, brokers, and issuers participating in direct enrollment. These third-party entities will be considered downstream and delegated entities of their respective DE entity partners. CMS anticipates this approach will reduce the regulatory burden on agents, brokers, and issuers utilizing direct enrollment.

Furthermore, as CMS considers potential expansions to the DE pathway, CMS anticipates that the oversight processes implemented for the DE pathway, including 45 CFR 155.221, will serve as the basis for the oversight approach for future DE functionality.

## **CHAPTER 6: FF-SHOPS**

In the 2019 Payment Notice Final Rule, CMS finalized substantial changes to how the FF-SHOPS will operate. Based on the policies finalized in the 2019 Payment Notice Final Rule, guidance from the 2018 Letter to Issuers regarding FF-SHOP operations is no longer applicable

for SHOP QHPs for the 2019 plan year. Issuers applying for certification of plans as QHPs to be offered through FF-SHOPs for plan years beginning in 2019 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

45 CFR 155.205(c) specifies access standards for certain entities, including QHP issuers and web-brokers, and includes language access standards with respect to oral interpretation, written translation, the use of taglines indicating the availability of language services, and website translation. Please refer to the 2018 Letter to Issuers for more information on these requirements.

As a reminder, QHP issuers that are also subject to the notice and tagline requirements in the regulations implementing section 1557 of the PPACA (45 CFR 92.8), will be deemed to be in compliance with §155.205(c)(2)(iii)(A) if they are in compliance with §92.8.

Additionally, we note that QHP issuers are not required to make available a printed copy of written translations of a formulary drug list pursuant to §155.205(c), unless doing so is necessary for providing meaningful access to an individual with a disability or an individual with limited English proficiency. Under §155.205(c) and §156.250, QHP issuers must make information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including the formulary drug list, accessible to individuals with disabilities and individuals with limited English proficiency. We consider a QHP issuer to be in compliance with the written translation requirements under §155.205(c) if the issuer's general practice is to make required written translations of the formulary drug list available on its website, as long as the issuer provides printed copies of the document to consumers who need a printed copy in order to access it.

### Section 3. Summary of Benefits and Coverage

Guidance on the Summary of Benefits and Coverage (SBC) remains unchanged from 2018, with the exception of the update below. Please refer to the 2018 Letter for additional information.

The 2017 SBC instructions for both individual and group market health plans require plans and issuers to disclose whether the plan for which they are preparing an SBC provides minimum value by indicating "Yes" or "No" in the minimum value disclosure line. HHS noted in the preamble to the 2015 Summary of Benefits and Coverage and Uniform Glossary Final Rule that

the concept of minimum value is not relevant with respect to individual market coverage and we would therefore not take enforcement action against an individual market issuer for omitting such a statement until the new template and associated documents were finalized and applicable.<sup>31</sup> While materials for the 2017 SBC were finalized in 2016, and are applicable for open enrollment periods or plan or policy years beginning on or after April 1, 2017, HHS will maintain this position of not enforcing against an individual market issuer for omitting the minimum value disclosure. Options for these plans include using “Not Applicable” or “N/A” for this section.

Finally, as a reminder, guidance on the SBC applies to all QHP issuers in the FFEs and 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.<sup>32</sup>

## **CHAPTER 8: TRIBAL RELATIONS AND SUPPORT**

CMS guidance concerning Indian health care providers remains unchanged; 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. Similar to plan year 2018, SBE-FPs will execute the Federal platform agreement with CMS for plan year 2019. For more information on this agreement and its implementation, please refer to the 2018 Letter to Issuers.

SBE-FPs for the individual market and/or for SHOP will retain the authority and primary responsibility for plan management functions, including QHP certification. As finalized in the 2019 Payment Notice Final Rule, CMS will continue to rely on SBE-FPs to perform plan data review for QHP certification standards. CMS will also continue to perform data integrity reviews of certain plan data relating to plan display on HealthCare.gov, such as annual re-enrollment at §155.335(j). CMS will continue to defer all QHP certification reviews for the individual market and/or SHOP to the SBE-FPs.

Pursuant to 45 CFR 155.200(f)(2), an SBE-FP for the individual market and/or SHOP must establish, oversee, and agree to enforce certain QHP and QHP issuer requirements that are no less strict than the requirements that HHS applies to QHPs and QHP issuers in the FFEs. However, as finalized in the 2019 Payment Notice Final Rule, CMS eliminated the requirement

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<sup>31</sup> Summary of Benefits and Coverage and Uniform Glossary, 80 FR 34292, 34297 (June 16, 2015).

<sup>32</sup> 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/cciiio/Resources/forms-reports-and-other-resources/index.html#Summary of Benefits and Coverage and Uniform Glossary](https://www.cms.gov/cciiio/Resources/forms-reports-and-other-resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary).

for SBE-FPs to enforce FFE standards for network adequacy at §155.200(f)(2)(ii), essential community providers (ECPs) at §155.200(f)(2)(iii), and the Federal meaningful difference standard at §155.200(f)(2)(iv). CMS has already stated in prior guidance that FFEs would rely on State reviews of network adequacy standards where the States have been determined to have an adequate review process, and CMS will show similar deference to SBE-FPs and state authority for these three standards. For the two standards that would remain under 45 CFR 155.200(f)(2) for SBE-FP issuers, CMS will continue to work collaboratively with SBE-FPs to enforce those standards.

As finalized in the 2019 Payment Notice Final Rule at 45 CFR §155.106(c), and per CMS guidance,<sup>33</sup> States will no longer be able to elect and seek approval to operate an SBE-FP for SHOP, although existing SBE-FPs for SHOP that are currently approved to operate as such by CMS would be able to maintain their existing status. The 2019 Payment Notice Final Rule also establishes that, for plan years beginning on or after January 1, 2018, requirements for issuers offering QHPs through SBE-FPs for SHOP related to sending enrollment/enrollment reconciliation files, along with other requirements related to the enrollment process at 45 CFR 155.200(f)(4), will no longer apply.

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<sup>33</sup> Center for Consumer Information and Insurance Oversight, CMS, The Future of the SHOP: CMS Intends to Allow Small Businesses in SHOPS Using HealthCare.gov More Flexibility when Enrolling in Healthcare Coverage (May 15, 2017), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPS-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf>.