CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

QHP Certification State Toolkit

Key Resources for FFEs, FFEs in States Performing Plan Management, and SPE-FPs

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Contents

PURPOSE OF THE TOOLKIT

The plan year (PY) 2021 Qualified Health Plan (QHP) Certification State Toolkit is a series of consolidated resources to which states may refer to throughout the QHP certification process. This toolkit consolidates important information such as states' roles and responsibilities throughout the QHP certification process, key dates and reminders, submission trainings and manuals for the System for Electronic Rate and Form Filing (SERFF) and Health Insurance Oversight System (HIOS), and additional resources for states. The toolkit is a supplemental resource and is not intended to replace official guidance or instructions.

The QHP Certification State Toolkit includes general guidance on the overall QHP certification process. Appendix A summarizes policy updates from the Notice of Payment & Benefit Parameters for 2021 and 2021 Letter to Issuers (LTI) in the Federally-facilitated Exchanges (FFE). Appendix B describes the Plan Management (PM) Community Functionality. Appendix C describes state flexibility for submission of Essential Health Benefits (EHB) benchmark plans. Appendix D outlines states' responsibilities for QHP certification reviews by Exchange type. Appendix E provides the PY 2021 QHP certification timeline. Appendix F describes each QHP certification review, roles by state Exchange type, and the applicable review tools. Finally, Appendix G provides a map of the PY 2021 Exchange Models.

WHERE TO FIND HELP

- For technical questions related to HIOS, contact the Marketplace Service Desk (MSD) at 1-855-CMS-1515 (1-855-267-1515) or CMS_FEPS@cms.hhs.gov
- For technical questions related to SERFF, contact the SERFF Plan Management Help Desk at serffplanmgmt@naic.org
- For questions regarding the PM Community states can review the PM Community User Guide
- For state-related questions, contact the Plan Management State Coordination (PMSC) mailbox at PlanManagementStateCoordination@cms.hhs.gov
- For Form Filing reviews in direct enforcement states, contact FormFiling@cms.hhs.gov
- For Rate Review questions, contact RateReview@cms.hhs.gov
- For general CCIIO information, see the CCIIO FAQs and Fact Sheets
- For key documents related to QHP certification, please reference the QHP certification website

QHP Certification Overview

Consumers and small employers have access to the Health Insurance Exchanges through the Patient Protection and Affordable Care Act (PPACA). Eligible consumers in every state and the District of Columbia are able to buy QHPs available through their states' Exchange. States operate their own Exchanges (State-based Exchanges, or SBEs) or allow the Federal government to facilitate the Exchange in their state (Federally-facilitated Exchanges, or FFEs). Some states perform plan management functions in FFEs, and some State-based Exchanges use the federal platform (SBE-FPs). **Table 1** describes the different plan management responsibilities of each Exchange model. Appendix G includes a map outlining each state's Exchange model.

Table 1. Responsibilities by Exchange Model

Exchange Model	Description of State Responsibilities
Federally-facilitated Exchange (FFE)	CMS, as administrator of the FFE, certifies QHPs while the state, with the exception of direct enforcement (FFE-DE) states (see **Appendix G**), enforces market-wide standards[1] under the PPACA. For FFE-DE states, CMS reviews rates and forms for compliance with PPACA provisions when states that inform CMS that they do not have the authority to enforce or are not otherwise enforcing one or more provision themselves.[2] Individuals can apply for and enroll in health insurance coverage, and small employers can apply for determinations of eligibility to participate in the Small Business Health Options Program (SHOP) through HealthCare.gov.
FFE in states performing plan management functions	The state makes QHP certification recommendations to CMS. CMS is responsible for final certification decisions for QHPs based on the state's recommendation. Individuals can apply for and enroll in health insurance coverage, and small employers can apply for determinations of eligibility to participate in the SHOP through HealthCare.gov.
State-Based Exchange Using the Federal Platform (SBE-FP)	The state performs plan management functions and certifies QHPs. The state uses HealthCare.gov and the federal IT infrastructure for plan display, selection, and enrollment. Individuals can apply for and enroll in health insurance coverage, and small employers can apply for determinations of eligibility to participate in the SHOP through HealthCare.gov.
State-based Exchange (SBE)	The state performs all Exchange functions for the individual market and/or the SHOP. Individuals can apply for and enroll in coverage, and small employers and their employees can apply for eligibility determinations and may be able to enroll in coverage through Exchange websites established and maintained by the states.

[1] Market-wide standards include essential health benefits (EHBs) and actuarial value (AV) reviews.
[2] CMS enforces market-wide standards under the PPACA for direct enforcement states. CMS expects all other states to enforce these market-wide standards.

States performing plan management functions in FFEs and SBE-FPs conduct certification reviews for issuers applying for QHP certification in their state. SBEs are responsible for performing all Exchange functions and therefore are not included in the table below. **Table 2** gives an overview of state plan management activities by Exchange Model.

Table 2. State Plan Management Overview

Federally-Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform (SBE-FP)
1. Read General Information - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series 2. CMS collects QHP Applications via HIOS - Review HIOS Manual 3. Confirm Initial List of Plans in the Plan Management (PM) Community - Review and confirm plan list 4. Review Correction Notices - Review notices and reach out to CMS, as needed 5. Confirm Final List of Plans in the PM Community - Review and confirm plan list	1. Read General Information - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series 2. Prepare for Reviews - Review Letter to Issuers for changes for upcoming plan year - Confirm state review responsibilities - Review tool summaries and functionality - Watch QHP Application review tool instructional videos - Review PY2021 Required Supporting Documents 3. Collect QHP Applications via SERFF - Review SERFF Manual - Watch SERFF trainings 4. Review Plans - Run review tools - Reach out to CMS Help Desk with questions as necessary at: CMS_FEPS@cms.hhs.gov 5. Transfer Plans - Coordinate transfer with CMS and SERFF, if needed 6. Confirm Initial List of Plans in the PM Community - Review and confirm plan list 7. Review Correction Notices - Review notices and reach out to CMS, if needed 8. Confirm Final List of Plans in the PM Community - Review and confirm plan list	1. Read General Information - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series 2. Prepare for Reviews - Review Letter to Issuers for changes for upcoming plan year - Confirm state review responsibilities - Review tool summaries and functionality - Watch QHP Application review tool instructional videos - Review PY2021 Required Supporting Documents 3. Collect QHP Applications via SERFF and/or State System - Review SERFF Manual - Watch SERFF trainings 4. Review Plans - Run review tools - Reach out to CMS Help Desk with questions as necessary at: CMS_FEPS@cms.hhs.gov 5. Transfer Plans - Coordinate transfer with CMS and SERFF, if needed 6. Confirm Initial List of Plans in the PM Community - Review and confirm plan list 7. Review Correction Notices - Review notices and reach out to CMS, if needed 8. Confirm Final List of Plans in the PM Community - Review and confirm plan list

QHP Application Data Collection

There are two primary systems issuers use to submit QHP Application data: the Health Insurance Oversight System, or HIOS, and the System for Electronic Rate and Form Filing, or SERFF.[3] The system that issuers use depends on their state's Exchange model type. States can review their issuers' data within the corresponding system with the appropriate login credentials. The QHP certification website provides more detail on the systems states are using for QHP Application and plan data review.

HIOS

Health Insurance Oversight System (HIOS) stores QHP Application data from issuers and SERFF, and CMS collects this material through HIOS. State users can register for the State Reviewer role in HIOS to review this data. For more information on how to obtain access to HIOS, refer to the HIOS User Manual or the HIOS Quick Reference Guide.

Questions related to HIOS should be directed to the Marketplace Service Desk (MSD) at 1-855-267-1515 or CMS_FEPS@cms.hhs.gov.

SERFF

System for Electronic Rate and Form Filing (SERFF) is used to collect QHP Application data. States performing plan management functions in FFEs and SBE-FP states (as applicable) collect QHP Application data through SERFF, and then transfer this data from SERFF to HIOS for CMS review.

States performing plan management functions in FFEs and SBE-FP states must transfer their QHP Applications from SERFF to HIOS. The SERFF data transfer deadline aligns with the HIOS QHP Application submission deadlines. State transfers should include all on-Exchange QHP and all on and off-Exchange SADP plans submitted to the state for certification. States can transfer through SERFF multiple times, and are strongly encouraged to transfer their plans early to avoid transmission delays. However, SBE-FPs should not transfer off-Exchange SADPs. For more information, refer to the SERFF State Manual and User Manual Appendix, or SERFF Plan Management Training.

Questions related to SERFF functionality should be directed to the SERFF Plan Management Help Desk at 816-783-8500 or serffplanmgmt@naic.org.

[3] Issuers are required to submit Plan ID Crosswalk Templates in the PM Community.

REVIEW TOOLS

CMS provides tools for issuers and states to review QHP Application data. States can download the review tools from the QHP certification website. **Table 3** provides summaries of the publicly available review tools. CMS developed a series of instructional videos on the QHP Application review tools, which are intended to help issuers and states use the review tools to check QHP Application data.

Table 3. Tools for States' QHP Certification Reviews

Review Tool	Description	Applicable Template(s)
Data Integrity Tool (DIT)	• Identifies critical data errors within and across templates. • Provides immediate feedback about data, reducing issuer resubmissions. • Alerts issuers and state reviewers to irregularities in the template submissions. • Imports QHP and stand-alone dental plans (SADP) data from most application templates. • Conducts validation checks beyond the standard HIOS and SERFF checks. • Looks across templates for consistency in key fields. • Produces error reports that describe the error and its location in the template.	Plans & Benefits; Business Rules; Network ID; Prescription Drug; Service Area; Rates Table; Unified Rate Review
Master Review Tool	• Aggregates data from the Plans & Benefits, Service Area, and Essential Community Provider (ECP)/Network Adequacy (NA), and Prescription Drug Templates. • Serves as a data input file to the other stand-alone tools. • Many tools require the import of a populated Master Review Tool in order to run, so CMS recommends this tool be used second, after the Data Integrity Tool has been run.	Plans & Benefits; Service Area; ECP/NA; Prescription Drug
Review Process Guide	• Provides model step-by-step processes that state regulators can follow to review QHP Applications for compliance with specific PPACA standards. This includes descriptions of the backend functionality in the other automated review tools. • This tool is a good reference for users to see the steps taking place in each of the standalone tools. This tool is also helpful in completing reviews that cannot be automated.	N/A

Review Tool	Description	Applicable Template(s)
Cost Sharing Tool	• Runs four different checks (when they are applicable to the plan) for cost sharing standards. This includes: Maximum Out of Pocket (MOOP) Review, Cost Sharing Reduction (CSR) Plan Variation Review, Catastrophic Plan Review, and Expanded Bronze Plan Review. • Note: For expanded bronze plan designs where the issuer covers at least one major service before the deductible, it is the State's responsibility to determine whether the submitted plan design's coverage of the major service uses a reasonable cost-sharing rate. In other words, if the plan covers a major service using the copay, the enrollee would be liable for cost sharing equivalent to 50% coinsurance or less.	Plans & Benefits *Master Review Tool is required to use this tool*
Essential Community Providers (ECP) Tool	• Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. • Checks whether the percentage of the plan's network ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 C.F.R. 156.235.	Plans & Benefits; Service Area; ECP/NA *Master Review Tool is required to use this tool*
SADP Essential Community Providers (ECP) Tool	• Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. • Checks whether the percentage of the plan's network ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 C.F.R. 156.235.	Plans & Benefits; Service Area; ECP/NA *Master Review Tool is required to use this tool*
Non-Discrimination Cost Sharing Tool	• Performs an outlier analysis for "QHP Discriminatory Benefit Design." • Reviews all plans within the state, goes through a group of pre-determined benefits and determines if any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.	Plans & Benefits *Master Review Tool is required to use this tool*
Formulary Review Suite	Includes the tools to run two reviews, including:	Prescription Drug

Review Tool	Description	Applicable Template(s)
	• ***Non-Discrimination Clinical Appropriateness Review***: Analyzes the availability of covered drugs associated with ten conditions as recommended in clinical guidelines, to ensure that issuers are offering a sufficient type and number of drugs. • ***Non-Discrimination Formulary Outlier Review:*** Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in 28 United States Pharmacopeial (USP) classes.	*Master Review Tool with Plans & Benefits data is recommended to use this tool*
Plan ID Crosswalk Tool	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring that: • All counties in all FFE plans (including FFEs in states performing plan management functions) that were offered in the previous plan year are included in the crosswalk; • The plans are crosswalked to valid plans; • The crosswalk reasons selected are consistent with plan offerings; and • The crosswalk is compliant with the regulation in 45 C.F.R. 155.335(j).	Plans & Benefits; Service Area; Plan ID Crosswalk
Category & Class Drug Count Tool	• Compares the count of unique chemically distinct drugs in each USPv7 category and class for each drug list against a state's benchmark.	Prescription Drug *Master Review Tool with Plans & Benefits data is recommended to use this tool*
Plan Preview Environment	• Displays plans to issuers, similar to how Plan Compare displays plans to consumers on HealthCare.gov. States with HIOS State Reviewer access can use Plan Preview to preview the plan benefit displays for all issuers in their state. • Issuers are also strongly encouraged to use Plan Preview to verify the accuracy of their plans' display to consumers before finalizing plan data. • MPMG will provide customized support to issuers to address their Plan Preview questions and provide issuers to a complete understanding of the Plan Preview system. Issuers should work with their Account Managers to schedule this support. • A helpful resource is the Plan Preview User Guide.	Plans & Benefits; Service Area; Business Rules; Rates Table

ADDITIONAL STATE ROLES IN QHP CERTIFICATION

QHP Notices

Throughout the QHP Application submission process, CMS releases review results to issuers in the PM Community on a rolling basis. These review results include required corrections that issuers need to make to their applications. As reviews are completed, CMS will update the PM Community with new corrections. Issuers and states are encouraged to log into the PM Community to review these corrections. See **Table 4** for an overview of the state and issuer roles for each notice. Appendix B provides more information on the Plan Management (PM) Community functionality.

CMS expects that states will establish the timeline, communication process, and resubmission window for any reviews conducted under state authority. 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.

Table 4. Overview of QHP Notices

Notice	State Response Requested	Issuer Response Requested
Initial Plan Confirmation	Yes. Return State Plan Confirmation Table to CMS in Plan Management (PM) Community.	No.
Alternate Enrollment Notices	Yes. States must tell CMS if they wish to select the specific plans into which consumers will be auto reenrolled.	No.
Final Plan Confirmation	Yes. Use the dropdown menus in the PM Community to complete plan confirmation for each plan.	Yes. Use the dropdown menus in the PM Community to complete plan confirmation for each plan.
Certification Notice	No.	No.

Plan Confirmation

States have two opportunities to confirm the plans submitted and reviewed for certification. After the close of the initial and final data submission windows, all FFEs, states performing plan management

functions in FFEs, and SBE-FPs[4] with issuers with an active QHP Application will receive plan confirmation notices.

What do states need to do?
FFEs, states performing plan management functions in FFEs, and SBE-FPs must review their plan lists and indicate whether the state approves the required regulatory submissions associated with the certification of on-Exchange plans in their state.

APPLICATION TIPS

- Watch the review tool videos to learn how to use the review tools and allow ample time to use the review tools.
- States using SERFF should transfer plans to HIOS early in case issues arise.
- Search the QHP certification website for answers to questions before contacting the CMS Help Desk.
- Attend state and issuer webinars to ask questions about the QHP certification process and learn about operational guidance (see REGTAP for more information and registration).

Plan ID Crosswalk and Alternate Enrollment

The Plan ID Crosswalk Template crosswalks the QHP standard component ID and service area combinations from the current plan year (e.g., Plan ID and county combinations) to a QHP Plan ID for the upcoming plan year. This data will facilitate 834 enrollment transactions from CMS to the issuer for those enrollees in the individual market Exchanges who have not actively selected a QHP during open enrollment. These instructions apply to QHP and SADP issuers that offered individual market QHPs on the Exchange. 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 plans offered during the 2021 plan year.

Issuers are expected to submit evidence from the state, such as a completed form, email confirmation, or State Authorization Form[5], that the issuer is authorized to submit its Plan ID Crosswalk.

What do states need to do?
Issuers submitting Plan ID Crosswalk templates in FFEs, states performing plan management functions, and SBE-FPs should submit evidence from the state, such as a State Authorization Form or an email confirmation, that the issuer is authorized to submit its Plan ID Crosswalk Template via the PM Community. States can return authorization forms directly to issuers.

[4] SBE-FP states must respond to final plan confirmation indicating their intent to CMS to certify listed plans.
[5] Use of this form is optional. A state may choose to develop its own form or method to document state authorization for submission via the PM Community.

Additionally, 45 CFR 155.335(j)(3) authorizes Exchanges to determine alternate enrollments for enrollees in QHPs where the issuer will have no Exchange enrollment option available to the enrollee for the upcoming plan year, unless otherwise directed by the state. In the FFEs, including FFEs in states performing plan management functions, and SBE-FPs this activity will apply to all QHP enrollees where the original issuer no longer has a QHP available to the enrollee through the Exchange for the upcoming plan year. This activity will not apply to SADPs or SHOP plans.

If the enrollee's current QHP is not available to the enrollee through the Exchange, and no QHPs from the original issuer are available to the enrollee for auto re-enrollment in the Exchange, and no direction is provided by the state, CMS, if feasible, will determine an alternate enrollment for affected enrollees. CMS will determine an alternate enrollment in another QHP available through the Exchange with a service area that covers the enrollee's location, taking into account the issuer's ability to absorb new enrollment and the lowest premium plan. This is done to help maintain coverage through the Exchange for affected enrollees who fail to return to the Exchange to make their own plan selection before Open Enrollment closes. Unless otherwise directed by the state, the Exchange directs such selections.

What do states need to do?
States that wish to direct this activity must notify CMS of this decision. CMS will send communications outlining the process states should take to submit pertinent decisions. States and CMS work closely to ensure state and issuer concerns are addressed throughout the alternate enrollment process.

Plan Withdrawal

In this context, plan withdrawal refers to withdrawing a plan from certification (or consideration of certification) as a QHP to be offered through the Exchange. This is distinct from (but sometimes a consequence of) discontinuing a product or withdrawing completely from the market—the individual market or small group market both inside and outside of the Exchange—in a state. An issuer's submission of the final plan confirmation list to CMS is generally the last opportunity for the issuer to withdraw a plan from certification consideration for the upcoming plan year. States may withdraw plans until the final state plan confirmation deadline. To withdraw a plan from QHP certification consideration, an issuer or state should submit a plan withdrawal form to CMS.

- **Withdrawal Form:**
  - Issuers and states can submit the Withdrawal Form through the PM Community by following the instructions on the QHP certification website.

Data Changes

The process for making changes to QHP data, including the state's role in approving data change requests from issuers, varies depending on the timing of the request within the QHP certification cycle. **Table 5** provides an overview of the acceptable data changes depending on the timing of the change request (i.e., during and after the initial application submission window, after the final QHP Application deadline, after final data submission).

Issuers may make changes to their QHP Applications without state or CMS authorization until the deadline for initial QHP Application submission. After the close of the initial QHP Application submission

window, issuers may not add new plans to a QHP Application or change an off- Exchange plan to be both on and off-Exchange. Issuers also may not change plan type(s) or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child- only plan. 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. Additionally, Administrative data changes, including URLs, should be made in HIOS Plan Finder or the QHP Supplemental Submission Module and do not require a data change request to CMS. For URL updates, CMS requires state approval for issuers to update their URLs. However, we do not require issuers to submit a state authorization form to CMS. By submitting URL changes in the Supplemental Submission Module, issuers are attesting that changes have been approved by the applicable state. Note that States can view any of their issuers' URL data by logging in to the HIOS State Evaluation Module and accessing an individual issuer's Supplemental Submission Module.

After the deadline for issuer changes to QHP Applications, issuers will only make corrections directed by CMS or by their state. States may direct changes by contacting CMS with a list of requested corrections. Issuers whose applications are not accurate after the deadline for issuers to change QHP Applications are then required to resubmit corrected data during the limited data correction window and may be subject to compliance action by CMS. Table 6 denotes which data change request documents need to be submitted to CMS by Exchange model.[6]

What do states need to do?

States performing plan management functions in FFE will be included on communications to issuers from CMS approving or denying data change requests and notifying the issuer and state when the state should transfer all data changes. SBE-FP states must notify CMS when they have approved a data change. After notification, CMS will schedule a date for the state to transfer the change to CMS.

How can states notify CMS of changes issuers need to make after the QHP Application deadline but before certification?

States may direct changes by contacting CMS with a list of required corrections to PlanManagementStateCoordination@cms.hhs.gov. States should only refer changes that would prevent an issuer's QHP certification if not made.

Does CMS communicate with states after a data change?

CMS may reach out to states after a data change to notify the state that the issuer has made an unapproved change (in addition to the approved change) or that the issuer did not make the change as requested. CMS requests that states reply to CMS with any additional information the state has on the changes, including whether the state approved the change or provided additional instruction to the issuer.

- CMS also emails all issuers and states when the data has been refreshed on HealthCare.gov.

[6] SBE-FP states coordinate and approve data change requests according to state guidelines.

Table 5. Overview of Allowable Data Changes During the QHP Certification Cycle

Timeframe	Allowable Data Changes	Data Change Request Required?
During the initial QHP Application submission window:	Issuers may make any changes to their data without CMS or state authorization, including adding or removing plans or changing plan type.	Data change request not required
After the initial QHP Application submission window:	Issuers may not add plans or change plan type. A data change request to CMS is required for changes to service area, and plan withdrawal forms are required to remove plans. For all other changes, issuers are not required to submit data change requests or document state or CMS Form Filing authorization to CMS.	Data change request required for service area changes only
After the final QHP Application deadline:	Issuers will only make corrections directed and approved by CMS or their state. Issuers will have a final opportunity to withdraw plans during the plan confirmation process.	Data change request not allowed
After final data submission:	No further data changes allowed prior to certification. CMS may allow issuers to make critical post-certification data changes in order to correct data display errors on HealthCare.gov and to align QHP display with products and plans approved by the state. Post-certification data changes require data change requests and state and CMS approval.	Data change request **required**

Table 6. Data Change Request Approval Process by Exchange Model (Post-QHP Certification)

Exchange Model	Issuer Data Change Request Form	State Approval Documentation	CMS Form Filing Approval Documentation
FFE	✓	✓	None
FFE-DE (QHP)	✓	None	✓
FFE-DE (SADP)	✓	Approval or Deferral required+	None
FFEs in States performing plan management functions	✓	None*	None

SBE-FPs retain the authority and primary responsibility for plan management functions, including review and approvals of data change requests.

+CMS requires either state approval documentation or documentation that the state declines to review the data change request.
*Issuers are not required to provide CMS with state approval documentation but do need state approval to make changes. Transferring plan data from SERFF to HIOS indicates state authorization.

APPENDIX A: UPDATES FOR PLAN YEAR 2021

Guidance from the HHS Notice of Payment & Benefit Parameters for 2021 and 2021 Letter to Issuers (LTI) in the Federally-facilitated Exchanges (FFE)

- **Value-based Insurance Design:** The HHS Notice of Payment & Benefit Parameters for 2021 notes that CMS is pursuing strategies that will assist in the uptake and offering of value-based insurance design by QHP issuers. Offering a value-based insurance design QHP would be voluntary for issuers. Issuers are encouraged to select services and cost sharing that work best for their consumers. These value-based insurance plan designs will empower consumers and their providers to make evidence-based health decisions.

- **Quality Reporting:** CMS will continue to require display of the QHP quality rating information for all Exchanges, including FFEs, FFEs in States performing plan management functions, State-based Exchanges (SBEs), and State-based Exchanges using the federal platform (SBE-FPs) for the 2021 plan year. CMS proposes that SBEs would continue to have the flexibility to display the quality rating information provided by HHS or to display the quality rating information based upon certain permissible state-specific customizations of the quality rating provided by HHS.

- **Transparency in Coverage Reporting:** CMS will integrate the transparency in coverage data collection into the QHP certification data submission process beginning in plan year 2021. Issuers will submit the transparency template in the same manner and using the same timeline as other QHP certification templates. Submissions will no longer be collected outside of the QHP certification timeline via an email box.

- **Summary of Benefits and Coverage (SBC):** QHP issuers are required to provide the SBC in a manner compliant with the standards set forth in 45 CFR 147.200. On November 7, 2019, CMS released an updated SBC coverage examples Calculator, Guide and Narratives for coverage examples, SBC Template, and other associated resources for SBCs describing plans or policies effective on or after January 1, 2021. These resources can be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources. Use of the SBC Calculator is not required. Plans and issuers may create their own calculator using the Guide and Narratives provided by HHS, or modify the logic of the Calculator to provide their own method of calculating estimated out-of-pocket-costs for the Coverage Examples, which may be more accurate based on their particular plan or policy design. Plans and issuers will be required to use the 2021 SBC Template and Instructions, the 2021 Guide and Narratives, and the 2021 Calculator, should they choose to use the Calculator, beginning on the first day of the first open enrollment period for any plan years (or, in the individual market, policy years) that begin on or after January 1, 2021, with respect to coverage for plan or policy years beginning on or after that date.

- **Medical Cost Scenarios:** Consumer testing of the SBC shows that hypothetical medical scenarios illustrating the consumer portion of medical costs, such as those found on the SBC, help consumers understand and compare health plan coverage options. In order to provide

consumers greater cost transparency for plan year 2021, CMS is considering whether to provide additional medical cost scenarios to QHP customers on HealthCare.gov.

- Machine Readable: The Machine Readable file posting deadline is August 19, 2020, which aligns with the deadline for issuers to change QHP Application data. This allows additional time for CMS to conduct any applicable technical assistance required to ensure the Machine Readable files are available by open enrollment.

APPENDIX B: PLAN MANAGEMENT COMMUNITY FUNCTIONALITY

The Plan Management (PM) Community is an online platform designed to improve CMS communication and coordination with issuers and states around QHP certification. Federally-facilitated Exchanges (FFEs), states performing plan management functions in FFEs, and State-Based Exchange Using the Federal Platform (SBE-FP) use the PM Community to view qualified health plan (QHP) Application data for issuers in their state, access content such as notices and other documents from CMS, submit plan withdrawal forms, and complete state plan confirmation. All states, including SBEs, also use the PM Community perform activities related to essential health benefit (EHB) benchmark selection.

The PM Community User Guide, available in the PM Community, includes detailed descriptions of the PM Community contents as well as instructions for performing QHP certification-related state activities within the portal. In addition, the PM Community includes instructional videos to help states learn more about various features in the PM Community, such as how to manage contacts, how to access and upload files, and how to how to use the "States" and "Issuers in Your State" tabs. These resources can be found under the QHP certification Resources tab.

State users access the PM Community via the CMS Enterprise Portal. To request access to the PM Community, state users should follow the requisite steps, including registering for an Enterprise Identity Management (EIDM) account in the CMS Enterprise Portal and requesting access to Salesforce via EIDM. Once users have access to Salesforce in the CMS Enterprise Portal, they can follow the instructions for requesting access to the PM Community found below. Should users require more detailed instructions, or have any questions about access, they should contact the Marketplace Service Desk (MSD).

Please note that CMS requests states identify up to three users (CMS recommends a minimum of two) to access the PM Community for their organization. When selecting users, states should identify individuals who conduct hands-on work related to their issuers' QHP certification. Users who access the PM Community to perform EHB activities count toward the cap of three users. States can designate different users throughout the course of the year as needed, as long as states do not exceed the maximum of three users at any point in time.

Instructions for Requesting Access to the PM Community Tile in the CMS Enterprise Portal:
Once users have requested and been granted access to Salesforce in the CMS Enterprise Portal, they can follow the steps below to request access to the PM Community tile in the CMS Enterprise Portal.

1. Log in to the CMS Enterprise Portal.
2. If you have gained access to Salesforce, the **Salesforce** tile will be displayed on the My Portal page. Click on this tile.
3. When you click on the **Salesforce** tile, the blue Salesforce Application tab will display. Click on **Application**.
4. In the top-right corner, click on **App Store** on the CMS App Launcher page.
5. On the CMS App Store page, type "QHP" into the Search Apps field. Click on the **QHP Plan Management Community** tile.
6. The CMS App Listing page for the QHP Plan Management Community will display. On the right side of the page, click **Send Request**.
7. The Request Details field will ask you to describe your role and any specific details about your request. Enter the requisite information and click **Send**.
8. Document the **Request Confirmation Number** you're given on the next screen. This confirms your request has been successfully submitted for approval; you will also receive this request confirmation number in an email.

PM Community Features for States

State users are able to use the PM Community to see information about each issuer that has applied for certification of QHPs in their state. State users can perform a number of activities in the PM Community, including:

- Managing state contacts for QHP certification-related communications;
- Viewing issuer- and plan-level data for all issuers in the state;
- Finding resources about EHB and submitting their EHB-benchmark plan;
- Submitting withdrawal forms;
- Completing plan confirmation;
- Accessing attachments, such as notices, from CMS; and
- Viewing corrections regarding their issuers' QHP Applications.

APPENDIX C: PLAN YEAR 2021 STATE FLEXIBILITY FOR ESSENTIAL HEALTH BENEFITS (EHB)

Starting in plan year (PY) 2020, CMS provided states with greater flexibility to select its EHB-benchmark plan by providing three new options for selection including:

Option 1 Selecting the EHB-benchmark plan that another state used for the 2017 plan year.

Option 2 Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year.

Option 3 Selecting a set of benefits, subject to certain requirements, that would become the state's EHB-benchmark plan. To select a new EHB-benchmark plan, the state must submit via the PM Community: an EHB State Confirmation Template, Actuarial Certification/Report, EHB-Benchmark Plan Document, and EHB-Benchmark Summary Chart Template.

However, states have the flexibility to forgo these options, and may instead retain their current EHB-benchmark plans. States that opt not to exercise this flexibility continue to use the same EHB-benchmark plan. States selecting an EHB-benchmark plan for PY 2022 must submit required documentation to CMS by May 8, 2020.

States also have the option to permit issuers to substitute benefits between benefit categories, pursuant to 45 CFR 156.115(b)(2)(ii). States opting to permit substitutions must notify CMS via the PM Community by May 8, 2020 for PY 2022. Instructions on how to submit required documentation for selecting an EHB-benchmark plan or notify CMS of a state's decision to opt in to allow EHB substitution between EHB categories can be found in t the PM Community.

APPENDIX D: PLAN YEAR 2021 STATE RESPONSIBILITY FOR QHP REVIEWS BY EXCHANGE MODEL

The table below outlines the reviews that states are generally responsible for conducting based on their Exchange Model.

Federally-Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform (SBE-FP)
• Licensure and Good Standing • Network Adequacy • Rate Outlier (in states with an effective rate review program) • Plan ID Crosswalk	• Accreditation • Cost Sharing Reduction Plan Variations • Data Integrity • Essential Community Providers • Licensure and Good Standing • Network Adequacy • Non-Discrimination – Cost Sharing • Organizational Charts/Compliance Plans • Plan ID Crosswalk • Prescription Drug Non-Discrimination – Clinical Appropriateness • Prescription Drug Non-Discrimination – Formulary Outlier • Program Attestations • Quality Improvement Strategy • Rate Outlier • SADP – Annual Limitation on Cost Sharing • SADP – EHB Benchmark • SADP – EHB Supporting Documentation and Justification • Service Area • Silver/Gold Review	• Accreditation • Administrative • Cost Sharing Reduction Plan Variation • Data Integrity • Essential Community Providers • Licensure and Good Standing • Network Adequacy • Non-Discrimination – Cost Sharing • Organizational Charts/Compliance Plans • Plan ID Crosswalk • Prescription Drug Non-Discrimination – Clinical Appropriateness • Prescription Drug Non-Discrimination – Formulary Outlier • Program Attestations • Quality Improvement Strategy • Quality Reporting • Rate Outlier • SADP – Annual Limitation on Cost Sharing • SADP – EHB Benchmark • SADP – EHB Supporting Documentation and Justification • Service Area • Silver/Gold Review

APPENDIX E: QHP CERTIFICATION TIMELINE

The table below provides the plan year 2021 QHP certification timeline for states to review in preparation for certification, as detailed in the 2021 Letter to Issuers in the Federally-facilitated Exchanges.

Activity	Dates
Initial QHP Application submission window	4/23/20
Optional Early Bird QHP Application submission deadline	5/19/20
CMS reviews Early Bird QHP Application data and releases results in the Plan Management Community	5/20/20 – 6/10/20
Initial QHP Application deadline	6/17/20
CMS reviews initial QHP Applications and releases results in the Plan Management Community	6/18/20 – 8/12/20
Initial deadline for the QHP Application Rates Table Template	7/22/20
Service area data change request deadline	8/11/20
Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates in the PM Community	8/12/20 –8/26/20
Transparency in Coverage data submission deadline	8/26/20
Deadline for issuers to change QHP Application	8/26/20
CMS reviews QHP Applications and releases results in the PM Community	8/27/20 – 9/16/20
CMS sends QHP Certification Agreements to issuers	9/15/20
Issuers return signed QHP Certification Agreements to CMS	9/15/20 – 9/23/20
States send CMS final plan recommendations	9/15/20 – 9/23/20
Limited data correction window	9/17/20 – 9/18/20
Machine Readable file posting deadline	9/18/20
Transparency in Coverage data resubmission deadline	9/18/20
CMS releases certification notice to issuers and states	10/5/20 – 10/6/20
Open Enrollment begins	**11/1/20**

APPENDIX F: QHP CERTIFICATION REVIEW ROLES BY STATE EXCHANGE MODEL

The table below lists reviews for plan year (PY) 2021 that CMS, as administrator of the Federally-facilitated Exchanges (FFE), and states will conduct to ensure issuers applying to offer QHPs through Exchanges meet and maintain applicable certification standards. State regulators should refer to this review table in preparation for PY 2021 QHP certification. CMS, as administrator of the FFEs, remains responsible for certifying QHPs for sale through the FFEs.

The **Review Area** and **Review Description** columns detail each standard with which issuers must comply to achieve QHP certification. The **Reference to Guidance** column directs states to existing guidance for states and issuers pertaining to this certification standard. The **Applicability by Type of QHP** column indicates whether the certification standard applies differentially to QHPs that are SADPs.

The **Reviewer** columns indicate the entity primarily responsible for reviewing QHP Application data to ensure its compliance with the applicable certification standard. If a state is the primary reviewer with CMS ratification, CMS intends to conduct a minimal review of the state's results of QHP Application reviews, and communicate any outstanding deficiencies to issuers. If the state is the primary reviewer with no CMS ratification, CMS will accept QHP Application data as submitted by the state without additional review. If CMS is the primary reviewer, no state review is expected.

Finally, the table indicates whether an applicable **review tool** is available. Applicable review tools can be found on the QHP certification website.

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
1	**Accreditation**	The review examines issuers' existing accreditation to determine whether a QHP satisfies the accreditation requirements.	2019 Letter to Issuers (LTI), Page 15	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
2	**Administrative**	The review ensures that issuers provide contact information (e.g., phone number, address, URL) which appears on HealthCare.gov for consumer use.	2014 LTI Page 45	All QHPs	CMS	CMS	State (No CMS ratification)	*No tool available.*
3	**Cost Sharing Reduction Plan Variation**	The review ensures that all plans on the Exchange offer cost sharing reduction plan variations that meet the standards for QHP certification, if applicable. The required plan variations are the limited and zero cost sharing plan variations, and three silver plan variations. The limited and zero cost sharing variations are available to Indians, and the silver plan variations are available to eligible enrollees with household incomes between 100 and 250 percent of the federal poverty level. All plan variations reduce cost sharing for the consumer. This review also checks whether plans labeled catastrophic or expanded bronze meet certain plan design requirements.	2019 LTI Page 18	Not applicable to SADPs	CMS	State (CMS ratifies)	State (No CMS ratification)	Cost Sharing Tool
4	**Data Integrity**	The review identifies critical data errors within and across templates that result in incorrect display of plan information to consumers, prevention of plan display to consumers, or regulatory noncompliance. The review also flags data as warnings,	2019 LTI Page 18	All QHPs	CMS	State (CMS ratifies)	State (CMS ratifies)	Data Integrity Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
		prompting the issuer to double-check that the flagged data are correct.						
5	**Essential Community Providers**	The review determines whether the issuer's provider networks are adequate with respect to inclusion of ECPs. ECPs include providers that serve predominantly low-income and medically underserved individuals. Inclusion of ECPs in issuer networks helps to ensure reasonable and timely access to a broad range of ECPs for enrollees in issuer service areas.	2019 LTI Page 14	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	QHP ECP and SADP ECP Tools
6	**Licensure and Good Standing**	The review ensures issuers have provided documentation that shows they have satisfied licensure and good standing requirements for the proposed QHP markets, service areas, and products.	2019 LTI Page 12	All QHPs	State (No CMS ratification)	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
7	**Network Adequacy**[7]	The review assesses whether issuers meet standard of "reasonable access" to providers of covered services. In states that do not perform sufficient network adequacy reviews, CMS will rely on an issuer's accreditation from an HHS-recognized accrediting entity, or review access plans for issuers without accreditation.	2019 LTI Page 13	All QHPs	State/CMS (No CMS ratification)	State/CMS (No CMS ratification)	State (No CMS ratification)[8]	*No tool available.*

[7] State/CMS indicates in the Exchange Stabilization Final Rule that states will conduct the review when CMS determines that the state performs sufficient network adequacy reviews and CMS will conduct the review when it does not.

[8] In the 2019 Payment Notice Final Rule, CMS eliminated the requirement for SBE-FPs to enforce the FFE standards for Network Adequacy and Essential Community Providers (ECPs) and deferred to state authority for enforcement. For more information please see pages 22 - 23 of the 2019 Letter to Issuers in the Federally-facilitated Exchanges.

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
8	**Non-Discrimination – Cost Sharing**	To ensure non-discrimination in QHP benefit design, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) as part of the QHP certification application process. QHPs identified as outliers may be given the opportunity to modify cost sharing for certain benefits if CMS determines that the cost sharing structure of the plan that was submitted for certification could have the effect of discouraging the enrollment of individuals with significant health needs. In states where CMS performs this review, CMS's outlier analysis will compare benefit packages with comparable cost sharing structures to identify cost sharing outliers with respect to specific benefits.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*Non Discrimination Cost Sharing Review Tool*
9	**Organization Charts/ Compliance Plans**	The review examines compliance plans that issuers submit to ensure that appropriate processes are in place to maintain adherence with applicable regulations and guidelines, as well as to prevent fraud, waste, and abuse. The organizational chart review ensures that the Compliance Officer reports to the board of directors (or other senior governing body).	2018 LTI Page 55	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
10	**Plan ID Crosswalk: General Crosswalk Requirements**	The Plan ID Crosswalk review for general crosswalk requirements includes cases in the individual market where an issuer renews coverage, consistent with the guaranteed renewability standards under	2019 LTI Page 11	All QHPs	CMS	State (CMS ratifies)	State (CMS ratifies)	Plan Crosswalk Validation Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
		45 CFR 147.106(e) and 155.335(j)(1). This review also includes cases in the individual market where an issuer non-renews or discontinues coverage, or continues the product but no longer serves one or more enrollees, consistent with §147.106(c) and 155.335 (j)(2), and selects a plan under a different product offered by the issuer for those enrollees who do not make another plan selection. In all cases, issuers must comply with applicable federal and state law.						
11	**Plan ID Crosswalk: Alternate Enrollments**	The Plan ID Crosswalk review for alternate enrollments includes cases in the individual market where an issuer non-renews or discontinues coverage consistent with 45 CFR 155.335(j)(3) and does not provide an enrollment option for affected enrollees for the upcoming plan year.	2019 LTI Page 11 2020 LTI Page 12	Beginning in plan year 2020, CMS applied the processes established for the 2020 plan ID Crosswalk Template to SADPs to support automatic re-enrollment.	State unless State defers to CMS (CMS ratifies)	State unless State defers to CMS (CMS ratifies)	State unless State defers to CMS (CMS ratifies)	Plan Crosswalk Validation Tool
12	**Prescription Drug Non-Discrimination– Clinical Appropriateness**	The review ensures that issuers offer sufficient numbers and types of drugs to effectively treat high cost and chronic medical conditions and do not restrict access by lack of coverage or inappropriate use of utilization management techniques. Drug lists are created using nationally ranked clinical guidelines.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Formulary Review Suite

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
13	**Prescription Drug Non-Discrimination – Formulary Outlier**	The review focuses on utilization management measures that an issuer may use, and it identifies and flags outlier plans that have an unusually low number of drugs that are unrestricted—not subject to prior authorization or step therapy requirements—in particular USP categories and classes.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Formulary Review Suite
14	**Program Attestations**	The review confirms that issuers agree to comply with FFE requirements and standards.	2018 LTI Page 9	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
15	**Quality Improvement Strategy**	The review examines issuer QIS submissions to ensure that issuers have appropriately completed the QIS Implementation Plan and Progress Report forms and assess whether they meet the QIS requirements as part of their QHP Applications.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (CMS ratification)	State (No CMS ratification)	*Master Review Tool*
16	**Quality Reporting**	The review ensures issuers have submitted their quality data and enrollee satisfaction survey results.	2019 LTI Page 15	Not applicable to SADPs or child-only plans	CMS	CMS	State (No CMS ratification)	*No tool available.*
17	**Rate Outlier**	Issuers with rates that are significantly lower than the rest of the rates in the Exchange may indicate issuers that are at risk for financial insolvency, which could create market instability. These low rates are identified using an outlier analysis for plans in the same geographic region and metal level.	2019 LTI Page 16	Not applicable to SADPs	State rate review process (No CMS ratification)	State rate review process (No CMS ratification)	State rate review process (No CMS ratification)	*No tool available.*
18	**SADP – Annual Limitation on Cost Sharing**	The review ensures that the maximum out of pocket amount for all dental plans is within the required limit.	2020 LTI Page 19	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	Cost Sharing Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
			2019 LTI Page 19					
19	**SADP – EHB Benchmark**	The review consists of comparing an issuer-submitted benefit package with the benefits covered by the applicable EHB benchmark plan (state and federal benchmarks). The compliance review for additional benefits not EHB, and for associated attestations, consists of additional checks of these benefits to ensure they comply with applicable standards defined in the PPACA.	2018 LTI Page 52	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
20	**SADP – EHB Supporting Documentation and Justification**	The review examines supporting documentation submitted by issuers who have changed their EHBs, by substitution, and verifies that the new benefit is actuarially equivalent to the original EHB and meets the standards of the EHB and the PPACA.	2018 LTI Page 52	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*
21	**Service Area**	The review confirms that issuers establish a service area that covers a minimum geographical area that is at least the entire geographic area of a county. If the issuer proposed a service area small than a full county, the review ensures issuers proposing to cover part of a county are doing so because partial county coverage is necessary, non-discriminatory, and in the best interest of potential enrollees.	2018 LTI Page 22	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available.*

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
22	Silver/Gold	The regulation requires that an issuer offering QHPs through an Exchange offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level throughout each service area in which the issuer applying for certification offers coverage through the Exchange. The FFEs will apply this certification standard by ensuring that both a silver and gold level QHP (and/or Multi-State Plan options) are offered throughout each individual and FF-SHOP service area in which the QHP issuer offers coverage. An issuer could meet this standard by offering Multi-State Plan options certified by the Office of Personnel Management (OPM) as described in Chapter 1, Section 4, "OPM Certification of Multi-State Plan Options" above in both silver coverage and gold coverage levels throughout each service area in which it offers QHPs through an Exchange.	2018 LTI Page 23	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Master Review Tool

APPENDIX G: PLAN YEAR 2021 EXCHANGE MODELS

Consumers and small businesses have access to Health Insurance Exchanges through the Patient Protection and Affordable Care Act (PPACA). The below map outlines the Exchange model that each state maintains.

Plan Year 2021 Exchange Models Map