Non-Standardized Plan Option Limit Exception Justification Form

Background

In the Notice of Benefit and Payment Parameters (NBPP) for 2025 Proposed Rule, CMS proposed an exceptions process at new §§ 156.202(d) and (e) that would permit issuers offering Qualified Health Plans (QHPs) through the Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal Platform (SBE-FPs) to offer more than two non-standardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional non-standardized plan options beyond the limit at § 156.202(b) have specific design features that would substantially benefit consumers with chronic and high-cost conditions.

Specifically, pursuant to proposed § 156.202(d), FFE and SBE-FP issuers would be permitted to offer more than two non-standardized plan options if these additional plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area.

Additionally, as part of this proposed exceptions process, at proposed § 156.202(e), issuers would be required to submit a written justification in a form and manner and at a time prescribed by CMS that provides additional details and explains how the particular plan design the issuer desires to offer above the non-standardized plan option limit of two satisfies the proposed standards for receiving an exception to this limit – namely, how the particular plan design would substantially benefit consumers with chronic and high-cost conditions.

Instructions for Submitting a Non-Standardized Plan Option Limit Exception Justification Form

First, provide the information requested below in order to identify the non-standardized plan option(s) you desire to have excepted from the non-standardized plan option limit at 45 C.F.R. 156.202(b), in accordance with proposed §§ 156.202(d) and (e).

Next, respond to each of the three questions below, ensuring to thoroughly substantiate each response. You must respond completely to each of the three questions; otherwise your request may be denied. After completing this form, combine it, along with any supplementary evidence you are providing to substantiate your responses, into a single PDF file.

Name the combined file using the following convention: [Issuer ID]_[State]_non-standardized_plan_option_limit_exception_justification_form, such as: "12345_MD_non-standardized_plan_option_limit_exception_justification_form.pdf." A separate justification form must be submitted for each non-standardized plan option you desire to have excepted from the non-standardized plan option limit.

After completing, combining, and naming the file, upload the combined file, along with your completed Plans and Benefits Template, in the Plans and Benefits section of the Marketplace Plan Management System (MPMS).

Clear Form

Provide the following information in order to identify the non-standardized option you desire to have excepted from the non-standardized plan option limit:

Health Insurance Oversight System (HIOS) Issuer ID:

Issuer State:

HIOS Plan ID:

Plan Marketing Name:

HIOS Product ID:

Network ID:

Service Area ID:

Formulary ID:

New/Existing Plan:

Plan Type:

Level of Coverage:

Question 1: Identify the specific chronic and high-cost condition(s) that this additional non-standardized plan option is intended for.

Question 2: Explain which benefit(s) within the Plans and Benefits Template would have reduced annual enrollee cost sharing (as opposed to reduced cost sharing for a limited number of visits) for the treatment of the specified condition(s) by 25 percent or more relative to the cost sharing for the same corresponding benefits in your other non-standardized plan offerings in the same product network type, metal level, and service area.

Question 3: Explain how the reduced cost sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s). Include any relevant studies, guidelines, or supplementary documents, as applicable.