§ 156.202 Non-standardized plan option limits.

A QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform:

(a) For plan year 2024, is limited to offering four non-standardized plan options per product network type, as the term is described in the definition of “product” at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

(b) For plan year 2025 and subsequent plan years, is limited to offering two non-standardized plan options per product network type, as the term is described in the definition of “product” at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs (c)(1) through (3) of this section), in any service area.

(c) For purposes of paragraphs (a) and (b) of this section, the inclusion of dental and/or vision benefit coverage is defined as coverage of any or all of the following:

(1) Adult dental benefit coverage as defined by the following in the “Benefits” column in the Plans and Benefits Template:

(i) Routine Dental Services (Adult);

(ii) Basic Dental Care—Adult; or

(iii) Major Dental Care—Adult.

(2) Pediatric dental benefit coverage as defined by the following in the “Benefits” column in the Plans and Benefits Template:

(i) Dental Check-Up for Children;

(ii) Basic Dental Care—Child; or

(iii) Major Dental Care—Child.

(3) Adult vision benefit coverage as defined by the following in the “Benefits” column in the Plans and Benefits Template: Routine Eye Exam (Adult).

(d) For plan year 2025 and subsequent plan years, an issuer may offer additional non-standardized plan options for each product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage (as defined in paragraphs (c)(1) through (3) of this section), and service area if it demonstrates that 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 the issuer's other non-

standardized plan option offerings in the same product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, and service area.

(1) The 25 percent reduction in cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions will be evaluated at the level of total out-of-pocket costs for the treatment of the chronic and high-cost condition for a population of enrollees with the relevant chronic and high-cost condition.

(2) The reduction in cost sharing must not be limited to a part of the year, or an otherwise limited scope of benefits.

(3) The reduction in cost sharing for these benefits cannot be conditioned on a consumer having a particular diagnosis.

(4) The required reduction in cost sharing only applies to the standard variant of the plan for which an issuer seeks an exception, and not to the income-based cost-sharing reduction plan variations required by § 156.420(a), nor to the zero and limited cost-sharing plan variations required by § 156.420(b).

(5) Issuers are limited to one exception per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, for each chronic and high-cost condition.

(6) Chronic and high-cost conditions that may qualify an issuer for this exception will be determined by HHS.

(e) An issuer that seeks to utilize this exceptions process is required to submit a written justification in a form and manner and at a time prescribed by HHS that:

(1) Identifies the specific chronic and high-cost condition that its additional non-standardized plan option offers substantially reduced cost sharing for, in accordance with the definition of “cost sharing” at § 156.20;

(2) Identifies which benefits in the Plans and Benefits Template are discounted to provide reduced treatment-specific cost sharing for individuals with the specified chronic and high-cost condition. These discounts must be relative to the treatment-specific cost sharing for the same corresponding benefits in the issuer's other non-standardized plan offerings in the same product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area. For the purposes of this standard, treatment specific cost sharing consists of the costs for obtaining services that pertain to the treatment of a particular chronic and high-cost condition—but not the costs for obtaining services that do not pertain to the treatment of the relevant condition. The issuer must identify all services for which the benefits substantially reduce cost sharing in the Plans and Benefits Template. These benefits must encompass a complete list of relevant services pertaining to the treatment of the relevant condition;

(3) Explains how the reduced cost sharing for these services pertains to clinically indicated guidelines and a representative treatment scenario for treatment of the specified chronic and high-

cost condition (and include any relevant studies, guidelines, or supplementary documents to support the application, as applicable). For the purposes of this standard, a representative treatment scenario is an annual course of treatment for a chronic and high-cost condition; and

(4) Includes a corresponding actuarial memorandum that explains the underlying actuarial assumptions made in the design of the plan the issuer is requesting to except. In this memorandum, an issuer must demonstrate how the benefits that are discounted to provide reduced treatment-specific cost sharing of at least 25 percent identified at § 156.202(e)(2) for the treatment of the condition identified at § 156.202(e)(1) under the excepted plan compare to the identified in-limit offering in the same product network type, metal level, inclusion of dental and/or vision coverage, and service area. This demonstration must specifically be in reference to the specific population that would be seeking treatment for the relevant condition and not the general population. This memorandum must also include an actuarial opinion confirming that this analysis was prepared in accordance with the appropriate Actuarial Standards of Practice and the profession's Code of Professional Conduct.

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