State Health Reform Assistance Network
Charting the Road to Coverage

A Guide to Meaningful Difference

Supporting Informed Consumer Choice

Overview:

1. **45 C.F.R. § 156.298(a):** To be certified as a Qualified Health Plan (QHP) in a Federally-facilitated marketplace (FFM), a plan must be considered *meaningfully different* from all other plans [in its subgroup].
2. **45 C.F.R. § 156.298(b):** For a plan to be *meaningfully different*, a reasonable consumer would be able to identify one or more material differences between the plan and other plans, within the service area and metal tier.
3. **79 Fed. Reg. 13744** : The policy goal is to ensure consumers' ability to readily compare plan choices.

How CMS Applies Meaningful Difference Standards

- The CMS assessment method applies to potential QHPs to be offered through the FFM
  - Includes FFM markets in states performing plan management functions.
  - Includes catastrophic plans.
- SBMs may consider following the same guidelines.

CMS TAKES FOUR STEPS TO CREATE SUBGROUPS FOR REVIEW:
1. EACH ISSUER'S PROPOSED QHPs
2. IN SAME OR OVERLAPPING COUNTIES/SERVICE AREAS
3. BY PLAN TYPE (HMO, PPO, ETC)
4. BY METAL LEVEL
EACH SUBGROUP IS REVIEWED TO DETERMINE WHETHER EACH PLAN DIFFERS FROM OTHERS IN THE SUBGROUP WHEN CONSIDERING *AT LEAST ONE* OF THE FOLLOWING CRITERIA:
1. Difference in provider network
2. Difference in formulary
3. Difference in cost sharing • $50 or more difference in both individual and family in-network deductibles • $100 or more difference in both individual and family in-network annual cost sharing limit
4. Difference in covered benefits
5. Difference in Health Savings Account eligibility
6. Difference in child-only, adult-only, or adult and child coverage offerings

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FLAGGED PLANS:

If CMS finds that two or more plans within a subgroup do not differ based on at least one of the criteria, those QHPs would be *flagged for additional review and follow-up*, and either:

A. The issuer would be given the opportunity to *amend its submission* for one or more of the identified health plans; or
B. The issuer would be able to *submit a justification to CMS* explaining:
    1) How the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus
    2) It is in the interest of consumers to certify as a QHP.

EXCEPTIONS:

1. **45 C.F.R. § 156.298(c) Limited Plans in County**: Plans submitted for certification in a particular metal level will not be subject to the meaningful difference requirement if HHS determines that plan offerings at that metal level are limited in that county (including catastrophic plans).
2. **45 C.F.R. § 156.298(d) Mergers and Acquisitions Transition Period:** During the first two years after a merger of two issuers or an acquisition of one issuer by another, FFEs may certify plans that were *previously offered* by either issuer without those plans meeting the meaningful difference standard
3. ***Stand-alone dental*** *will not be reviewed* by CMS for meaningful difference.

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