Plan Year 2024 Guidance for Plan Marketing Names

45 CFR § 156.225(c), as finalized in the 2024 Notice of Benefit and Payment Parameters, requires that qualified health plan (QHP) and plan variation ("variant") marketing names include correct information, without omission of material fact, and don't include content that is misleading.[1]

Issuers may, but aren't required or encouraged to, add cost sharing and/or other benefit information to a plan marketing name. If included, the information must accurately reflect the plan benefits on a plan variant level, including any limitations or cost variations based on provider network or drug formulary tiering, benefit category, or service type.[2] In addition, plan marketing names that exceed 100 characters may be truncated in parts of online Marketplace user interface (UI) displays and experiences for accessibility, and include an ellipsis or similar element to indicate additional content that would be available through an interaction.

Examples below are not all-inclusive, but illustrate the types of plan marketing name characteristics for which the Centers for Medicare & Medicaid Services (CMS) may direct issuers to make corrections for compliance with 45 CFR § 156.225(c).

1) Deductible or maximum-out-of-pocket (MOOP) information for plans with non-integrated deductibles, and/or provider network or prescription drug tiered deductibles, must either specify if the deductible amount refers to one of the non-integrated deductibles, such as "Medical," "Health," or "Drug"; remove references to a deductible or MOOP; or list the combined deductible or MOOP.[3] Issuers may use "Medical" or "Health" interchangeably for Medical deductible or MOOP values that don't include "Drug" values.

   If including a number without a modifier that refers to a deductible or MOOP, we encourage issuers to include the full amount for which an enrollee may be responsible, and if possible, to use a dollar symbol to indicate dollar amounts. In addition, abbreviating modifiers such as "Ded" or "MOOP" may not be understood by consumers.

Example 1: Plan has $2,000 medical and $500 drug deductible	
Compliant: ABC Health $2,000 Health Deductible; OR ABC Health $2,500 Ded; OR ABC Health 2500	Not Compliant: ABC Health 2000 Deductible

Example 2: Plan deductible only applies to tier 1 providers	
Compliant: ABC Health $2,000 Medical In-Network Tier 1 Deductible	Not Compliant: ABC Health 2000 Deductible

[1] In practice, CMS and interested parties often use the term "plan variants" to refer to "plan variations," which is defined at 45 CFR §156.400.

[2] "Tiering" refers to how a plan may indicate different costs within a benefit category, usually drugs or provider network. For example, § 156.235(a)(2)(i) refers to plans with tiered provider network structures, and the Uniform Glossary of Health Coverage and Medical Terms describes how drug formulary tiers work (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf).

[3] "Non-integrated deductible" means a plan has separate deductibles that apply to specific services or groups of services – most commonly, a medical deductible and a drug deductible.

2) Cost-sharing information must include any applicable limitations to a certain prescription drug category, specific providers, or to a certain number of visits.

Example 1: Plan cost sharing amount only applies for a limited number of visits	
Compliant: ABC Health Preferred Silver - 3 $0 Copay PCP visits	Not Compliant: ABC Health Preferred Silver $0 Primary

Example 2: Plan has $0 copay for 90-day supply of generic prescription drugs from mail provider	
Compliant: ABC Health Silver Care 0 Copay for Generic Mail Order Drugs from Select Provider	Not Compliant: ABC Health Silver Care 0 Drug Copay

Example 3: Plan has $0 copay for visits scheduled with in-network (e.g., "ABC-care," a plan-specific name for in-network providers) or with a specific network tier of providers	
Compliant: ABC Health Bronze $0 Copay PCP visits with ABC-care provider	Not Compliant: ABC Health Bronze $0 PCP

Example 4: Plan has $0 copay for in-network telehealth visits only	
Compliant: ABC Health Bronze 0 Copay for Virtual PCP visits with ABC-care providers	Not Compliant: ABC Health Bronze $0 PCP; OR ABC Health Bronze $0 Doctor Visits; OR ABC Health Bronze Free Doc Visits

Example 5: Plan has a copay structure that differs based on provider or other benefit type	
Compliant: ABC Health $50 Copay PCP / $70 Copay specialist; OR ABC Health $50 Copay PCP	Not Compliant: ABC Health $50 Doctor visits

3) Plan marketing information must be accurate, and match corresponding information in the Plans & Benefits Template, and/or in other publicly available plan materials such as the Summary of Benefits and Coverage (SBC), plan brochure, and any other plan materials.

If a plan marketing name refers to benefits such as telehealth coverage, gym access, transportation, et cetera, then descriptions of the benefit(s) and associated cost sharing should appear in publicly available plan policy documents, such as the plan brochure and/or the SBC.

Example 1: Plan has integrated deductible of $1,500 based on information in the Plans & Benefits Template	
Compliant: ABC Care $1,500	Not Compliant: ABC Care $500 Ded

Example 2: Plan refers to transportation benefits in variant marketing name (e.g., ABC Health Bronze Value +Transportation)	
Compliant: Plan brochure includes description of transportation benefit with information on cost, quantity, and transportation type; SBC may also list this benefit under "Other Covered Services."	Not Compliant: Transportation benefit is not mentioned in plan brochure or any other materials

4) Plan marketing information must be consistent with and clearly resemble the plan or plan variant marketing name in other plan documents, such as the SBC, even if it is not identical.

Example 1:	
Compliant: **Plan Variant Marketing Name:** ABC Plan CommunityHealth Plus 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+ **Plan Name Listed on SBC:** ABC Plan CommunityHealth Plus	Not Compliant: **Plan Variant Marketing Name:** ABC Plan CommunityHealth Plus 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+ **Plan Name Listed on SBC:** CoveragePlus ABC Health 5000 Telehealth Low cost PCP

5) Plan marketing information must not include references to benefits that the Affordable Care Act (ACA) requires all QHPs to cover as though they were unique to that plan, such as "no exclusions for pre-existing conditions."

Example 1:	
Compliant: ABC Health 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+	Not Compliant: ABC Health 2000 Medical Deductible, 3 $0 Copay PCP visits, No pre-existing condition limitations

6) Plan marketing information must not indicate Health Savings Account (HSA) eligibility if the plan is not a high deductible health plan (HDHP).

Example 1:	
Compliant: ABC Health $0 Deductible, $0 PCP visits, SuperSaver	Not Compliant: ABC Health $0 Deductible, $0 PCP visits, SuperSaver, HSA

7) Plan marketing information must not exceed 150 characters, including spaces. Marketing names that exceed 100 characters with spaces may be truncated in display.

Example 1:	
Compliant: myABC EliteSpecialtyQuality Silver ($0 Primary Care Visits / $0 Specialist Visits with Select Providers / 24x7 Access with ABCDSelectTelehealth++) **Possible Online Display:** myABC EliteSpecialtyQuality Silver ($0 Primary Care Visits / $0 Specialist Visits with Select Provi…	Not Compliant: myABC EliteSpecialtyQuality Care Silver 455234C ($0 Primary Care Visits / $0 ABCDSelect+ Specialist Visits with ABCD456++Select Providers / 24x7 Provider Access with ABCDSelectTelehealth++ / No cost prescription drugs / Gym access 24/7 / $5 labs at participating providers / Rewards $$$)