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COMMISSIONER JOHN F. KING

GEORGIA ACCESS

Georgia Access Plan Year (PY) 2027 Qualified Health Plan (QHP) Application Instructions for Issuers

Release Date: 05/20/2026

Change Log

Date	Sections	Change Description
3/25/2026	N/A	• Initial release.
3/30/2026	N/A	• Update: Window Shopping & OE Period
5/20/2026	1.1 Key Updates for PY 2027 4.4 Essential Community Providers	• Based on the finalized 2027 NBPP, removed proposed language reducing the ECP compliance threshold to 20%.

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1 Introduction

Georgia Access is a division within the State of Georgia's Office of Commissioner of Insurance and Safety Fire (OCI). The Georgia Access Division is responsible for operating and managing Georgia's State-based Exchange (SBE), including certifying health and dental plans as Qualified Health Plans (QHPs) offered on Georgia Access. Georgia Access closely coordinates with OCI's Insurance Product Review (IPR) Division and examiners to review and confirm compliance of all plans offered on Georgia Access. IPR is responsible for reviewing and approving insurance product filings and policy forms in Georgia. Examiners are external parties appointed by IPR according to Georgia Insurance Code (Sections 33-2-11 to 33-2-15).

These instructions are for issuers requesting QHP certification to sell Affordable Care Act (ACA)-compliant plans on Georgia Access for PY 2027, including:

1. On-Exchange individual market health plans.
2. On-Exchange individual market Stand-Alone Dental Plans (SADPs).
3. On-Exchange small group market plans, known as Small Business Health Options Program (SHOP) plans.

All plans offered on Georgia Access must go through the QHP certification process annually (i.e., the PY 2027 QHP certification process is generally the same for both plans that were and plans that were not certified for PY 2026).

All issuers that intend to participate on Georgia Access for PY 2027 must complete the activities and follow the instructions outlined within this document. If an issuer does not meet the deadlines to obtain required approvals in a timely manner, the issuer may not be permitted to participate in Georgia Access for PY 2027.

Any updates to this document will be communicated to issuers via email, and a revised document will be posted on the Georgia Access website and the System for Electronic Rates & Forms Filing (SERFF). Issuers may submit questions regarding the Georgia Access QHP certification requirements and timeline to PlanManagement@GeorgiaAccess.ga.gov.

1.1 Key Updates for PY 2027

The list below outlines the key updates made to Georgia Access's QHP certification process and other issuer guidance for PY 2027, with links to the relevant sections throughout this document, where applicable.

1. **Off-Exchange only SADPs:** Georgia Access will no longer review off-exchange only SADPs for QHP certification. As occurs today, OCI Product Review will provide guidance on plan filing requirements for off-exchange only plan offerings.

2. **Network Adequacy (NA) Methodology, Time and Distance Standards, and Georgia Network Adequacy Template:**
   Georgia will continue to use CMS time and distance standards to determine network adequacy for PY 2027 QHP certification. Georgia **is updating its time and distance calculation methodology for PY 2027** to better reflect consumer access. This approach aligns with the updates CMS made for PY 2026.
   - **Drive distance** will be calculated based on available road networks to the

closest in-network provider location using CMS consumer sample data.
- **Drive time** will be calculated by dividing the distance (in-miles) by the speed limit along each route segment.

In addition, the **alternative time and distance standards** established by CMS will also be incorporated into the network adequacy analysis beginning with PY 2027 QHP Certification.

Georgia is introducing a new **Georgia Network Adequacy Template** for PY 2027 network adequacy reviews, which will replace the NA tab from the CMS ECP/NA Template. The new provider data template will be submitted under the **Supporting Documentation** tab in SERFF. Issuers must still submit **ECP data** using the CMS ECP/NA Template, which should include dummy data for the Network Adequacy tab. *Section 2 PY 2026 QHP Application & Certification Timeline*, *Section 4.5 Network Adequacy*, and *Section 9.2 Quarterly Network Adequacy Reviews*.

3. **Health Savings Account (HSA) Eligible Plans:** In accordance with Public Law 119-21, all individual market QHPs offered on the Exchange at the bronze, expanded bronze, and catastrophic metal levels will be regarded as high-deductible health plans. Georgia is requiring issuers to indicate a value of "yes" for the HSA eligible field in the Plans and Benefits template for all applicable metal levels.

2 PY 2027 QHP Application & Certification Timeline

Issuers requesting QHP certification for PY 2027 must meet the timeline below for application data submission and review. The timeline also includes submission deadlines for off-Exchange plans and reinsurance-related materials. Please note, dates are subject to change.

Activity	Reference Section(s)	PY 2027 Dates(s)
On-Exchange issuers submit a **Notice of Intent** for PY 2027 participation.	*Section 3*	4/1/2026 – 4/16/2026
Issuers complete template validation in HIOS MPMS and submit initial QHP Application materials in SERFF.	*Section 4* *Section 5*	4/16/2026 – 5/28/2026
See *Section 5 QHP Application Material Requirements & Submission* for a complete list of materials and submission locations.	*Section 4* *Section 5* *Section 10*	5/28/2026
State starts reviewing initial applications and working with issuers to make corrections.	*Section 5*	5/29/2026
Off-Exchange-only Plan & Rate Filing Deadline: Initial deadline for issuers to submit off-Exchange-only individual market medical plans and rates, off-Exchange SADPs, and off-Exchange-only small group (non-SHOP) plans and rates to the State. These plans are not considered for QHP certification.	*Section 5*	7/1/2026
Deadline for issuers to submit updated **Georgia Network Adequacy Template with PY 2026 and PY 2027 network adequacy data as of 6/17/2026** to SERFF.	*Section 4* *Section 5*	7/1/2026
Withdrawal Deadline: Final deadline for issuers to request to withdraw plans from QHP certification consideration.	*Section 6*	7/23/2026

Activity	Reference Section(s)	PY 2027 Dates(s)
Individual QHP Rates without Reinsurance Deadline: Deadline for issuers to submit rates for all on-Exchange individual QHPs **without** reinsurance.	*Section 4*	7/30/2026
State provides issuers with updated **Renewal and Discontinuation Notice Templates**.[1]	N/A	Mid-July 2026
Final Application Deadline for issuers to submit final QHP application materials in SERFF. Changes are not allowed to application materials after this date unless approved by the State.	*Section 8*	8/6/2026
Deadline for issuers to submit **Network Adequacy Justifications** to SERFF.	*Section 4* *Section 5*	8/24/2026
State reviews final QHP/SADP application materials and works with issuers to make corrections.	*Section 4* *Section 5*	8/7/2026 – 8/14/2026
Issuers and Georgia Access conduct **initial plan validation** in the Georgia Access Plan Management Module. This includes formulary testing.	*Section 7*	8/19/2026 – 09/24/2026
SBC PDF Submission Deadline: Deadline for QHP issuers to submit PDFs for a subset of their on-Exchange SBCs.	*Section 4*	8/20/2026
Provider JSON Submission Deadline: Deadline for issuers to submit their PY 2027 Provider JavaScript Object Notation (JSON) files on the State's Secure File Transfer Protocol (SFTP) site.	*Section 4*	9/1/2026
Issuer URL Template Submission Deadline: Deadline for issuers to submit the Issuer URL Template containing **live and active URLs.**	*Section 4*	9/3/2026
Machine-Readable URL & Technical POC Deadline: Deadline for issuers to submit their machine-readable URLs and technical Points of Contacts (POCs).	*Section 4*	9/3/2026
Medical Loss Ratio (MLR) Deadline: Deadline for issuers to submit MLR information to Georgia Access.	*Section 4*	9/3/2026
Issuers and Georgia Access conduct **Provider Directory Testing and URL plan validation** in the Georgia Access Plan Management Module.	*Section 4* *Section 7*	9/7/2026 – 9/24/2026
Plan Verification Deadline: Deadline for issuers to update plans to "Verified" in the Georgia Access Plan Management Module.	*Section 7*	9/24/2026
State sends **Certification Notices** to issuers.	*Section 7*	9/24/2026
Window Shopping	N/A	10/13/2026 -
Open Enrollment Period	N/A	10/19/2026 - 12/15/2026

3 Georgia Access Participation Readiness

In addition to following the timeline for application data submission and review, issuers must complete the activities below to prepare to participate in Georgia Access. The Notice of Intent is non-binding and for informational purposes only for the State. However, the requirements to confirm system access, complete issuer testing, and sign a Business Associate Agreement (BAA) are required.

[1] *The specific date for this activity depends on when CMS makes updates to their notice templates.*

1. **Confirm System Access:** Issuers must have access to the necessary submission systems and systems in which issuers review and test plan data. **Returning issuers** should confirm their continued access to the following systems:
    a. SERFF
    b. HIOS MPMS Plan Validation Workspace
    c. State's ShareFile
    d. State's SFTP site (for Electronic Data Interchange (EDI) and JSON file submissions)
    e. Georgia Access Plan Management Module (the "Issuer Representative" role)
    f. Georgia Access Ticking System (the "Issuer Enrollment Representative" role)

    New issuers should email PlanManagement@GeorgiaAccess.ga.gov as soon as possible to begin the onboarding process, and take the steps below to gain access to submission systems.
    a. To gain access to SERFF, visit SERFF Getting Started and contact serffhelp@naic.org with questions about access.
    b. To gain access to the HIOS MPMS Plan Validation Workspace, refer to the HIOS User Quick Reference Guide and the MPMS Module User Guide on CMS's QHP certification website's Submission Systems webpage. Contact CMS_FEPS@cms.hhs.gov with questions about access.
    c. To gain access to ShareFile, the Plan Management Module, ticketing system, and the State's SFTP site, contact PlanManagement@GeorgiaAccess.ga.gov.

2. **Submit a Notice of Intent:** The State requests all on-Exchange issuers (both new and returning) submit a non-binding Notice of Intent to participate in Georgia Access for PY 2027. This notice is intended to provide the State with information on each issuer participating for PY 2027 across Georgia's individual and SHOP markets and to confirm new issuers are included on all relevant communications. Issuers submit a Notice of Intent for each HIOS Issuer ID + product type (QHP/SADP) + market type (Individual/SHOP) combination that will be active in Georgia Access.

    The notice is submitted through ShareFile and captures the following information:
    a. Issuer name and HIOS Issuer ID.
    b. Confirmation of issuer's intention to participate for PY 2027.
    c. Issuer's intended market type(s) (individual/SHOP).
    d. Issuer's intended product type(s) (QHP/on- Exchange SADP).
    e. Issuer's intended service area(s) (i.e., counties that the issuer's plans will cover).
        i. Returning issuers are asked to confirm whether they are expanding into or leaving any counties compared to the previous plan year, confirm whether any expansions/contractions are in partial counties (and if so, which zip codes are included), and provide the reasoning for any intended changes. Returning issuers are also asked if they intend to add or discontinue any plans from the previous year.
        ii. New issuers are asked to provide the counties in which they intend to offer plans.
    f. Issuer contact information (new issuers only).

    Information submitted as a part of the Notice of Intent is non-binding; submission of the Notice of Intent does not require the issuer to file a QHP application. The Notice of Intent also does not guarantee issuer approval or plan certification. Issuers that do not submit a Notice of

Intent by the deadline but wish to offer plans in Georgia Access for PY 2027 should contact PlanManagement@GeorgiaAccess.ga.gov.

3. **Complete Issuer Testing *(For New Issuers Only)*:** New on-Exchange issuers must complete issuer testing with the Georgia Access Eligibility System vendor. This includes EDI 834 Testing, Reconciliation (RCNI) Testing, PayNow Integration Testing, and Provider Directory Testing. SHOP-only issuers do not complete issuer testing. Returning issuers are not required to repeat issuer testing activities each year. The State provides new issuers with information on issuer testing after issuers submit their Notice of Intent. This includes technical documentation, test plans, timelines, and platform onboarding activities.

4. **Sign an Issuer Business Associate Agreement (BAA):** Issuers must sign a BAA with OCI attesting to the operational and technical standards, privacy requirements, and security protocols required by the State. Refer to *Section 12 Issuer Business Associate Agreements* for more information on issuer BAAs.

   Note: Issuers operating as an Enhanced Direct Enrollment partner will also need to sign the EDE BAA and comply with annual certification requirements ahead of each open enrollment period.

Issuers that are new to Georgia or planning to offer on-Exchange individual or small group plans for the first time should contact Georgia Access at PlanManagement@GeorgiaAccess.ga.gov as soon as possible to begin the onboarding process.

4 QHP Certification Criteria

This section provides an overview of the application sections, federal and Georgia-specific QHP certification requirements, and associated federal regulations. The criteria outlined below are the same for new and returning issuers. All criteria apply to SADPs unless noted otherwise.

4.1 State Licensure and Good Standing

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.200(B)(4)

Issuers must be licensed and be in good standing with the State to offer plans on Georgia Access.

1. Each issuer must be licensed in Georgia to offer QHPs/SADPs for the applicable market, product type, and service area.
2. Each issuer must be in good standing (having no outstanding sanctions imposed by the State) and in compliance with state laws (demonstrating compliance with all applicable state solvency and regulatory requirements) to offer health coverage.

New issuers intending to offer plans on Georgia Access for the first time in PY 2027 must be licensed by OCI by **the final application deadline** and otherwise meet all requirements and deadlines outlined in this document. Georgia Access coordinates directly with OCI's Insurance Financial Oversight (IFO) Division to confirm that new issuers are on track to obtain licensure by the final application deadline, and validate that new issuers are meeting all QHP application deadlines and requirements.

New issuers for PY 2027 should contact PlanManagement@GeorgiaAccess.ga.gov as soon as possible to begin the onboarding and licensure process.

4.2 Accreditation

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.275; 45 CFR 155.1045

This section regarding accreditation does not apply to SADPs.

All QHP issuers must meet the standards for accreditation and authorize the release of their accreditation survey information to Georgia. Georgia Access follows the Federally-facilitated Exchange (FFE) accreditation standards and timeline. The recognized accrediting entities are Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), or Utilization Review Accreditation Commission (URAC).

Issuers must receive accreditation no less than **90 days** prior to OE; additional details are below.

1. For an issuer's first year of QHP certification, regardless of certifying entity[2], the issuer must have a scheduled review, or a plan to schedule a review, of QHP policies and procedures with a recognized accrediting entity. Issuers do not need to be accredited in their initial year of QHP certification but must be accredited 90 days before the first day of OE when entering any subsequent year of QHP certification.
2. Issuers entering their second or third year of QHP certification, regardless of certifying entity[3], must be accredited by a recognized accrediting entity 90 days prior to OE on the policies and procedures that are applicable to its Exchange products, or receive commercial or Medicaid health plan accreditation granted by one of the recognized accrediting entities.
    a. Second- and third-year issuers that are pursuing Exchange certification after their initial year of certification and have an accreditation status of “scheduled” or “in process” should upload documentation to SERFF from their accrediting entity indicating that they have completed the policies and procedures review and are scheduled for or are in the process of completing additional review.
3. Issuers entering their fourth year (or later) of QHP certification must have Exchange health plan accreditation 90 days prior to OE with one of the following statuses:
    a. AAAHC: Accredited
    b. NCQA: Accredited or Provisional
    c. URAC: Full or Conditional

Issuers that were previously QHP certified but did not pursue certification in the preceding year and are pursuing certification in the current year, are considered second-year issuers, and are held to the second-year accreditation standard.

Issuers moving consumers from one HIOS Issuer ID to another must ensure that the HIOS Issuer ID receiving enrollments meets at least the same accreditation standards as the previous HIOS Issuer ID. For example, an issuer cannot crosswalk consumers from Issuer A (a fourth-year issuer) to Issuer B (a first-year issuer), unless Issuer B meets the fourth-year accreditation standards outlined above.

4.3 Service Area

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1055; 45 CFR 156.200(c)(1)

Issuers must meet minimum geographic service area requirements for QHPs set by the State.

1. For a service area, a QHP must cover a minimum geographic area that is at least the size of the entire county.

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[2] The FFE was the certifying entity for Georgia’s QHPs for plan years before PY 2024. Georgia Access has been the certifying entity since PY 2024.

a. Issuers that wish to cover a partial county must provide sufficient justification for State approval that outlines why serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

2. Issuers that want to change a plan's service area after initial data submission but before the final application deadline must send an email to PlanManagement@GeorgiaAccess.ga.gov detailing the change for the State.
3. Issuers may not make changes to their service areas after the final application deadline.
4. QHPs must be offered on-Exchange at both the silver and gold coverage levels throughout each service area in which the issuer applying for certification offers coverage.

4.4 Essential Community Providers

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.235

ECPs are providers that serve predominantly low-income and medically underserved individuals. Issuers are required to include ECPs in their networks to help ensure reasonable and timely access to a broad range of ECPs for enrollees. Issuers must have a sufficient number and geographic distribution of ECPs, where available. There are two ECP standards: the general ECP standard and the alternate ECP standard.

To satisfy the general ECP standard, QHP issuers must:

1. Contract with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network.
2. Offer contracts in good faith to all available Indian Health Care Providers in the plan's service area for the plan year.
3. Offer contracts in good faith to at least one ECP in each ECP category in each county in the service area for the plan year, where an ECP in that category is available. The ECP categories are:
    a. Federally Qualified Health Centers
    b. Ryan White Program Providers
    c. Family Planning Providers
    d. Indian Health Care Providers
    e. Inpatient Hospitals
    f. Mental Health Facilities
    g. Substance Use Disorder Treatment Centers
    h. Other ECP Providers

To satisfy the alternate ECP standard, QHP issuers must:

1. Contract with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network.
2. Offer all categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the General ECP standard, or offer a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area for the plan year.

Issuers that exhaust all efforts to meet ECP standards but are unable to do so by the State's deadlines are required to submit a justification. At a minimum, such justification must include:

1. The number of contracts offered to ECPs for the plan year.

2. The number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations.
3. The names of the specific ECPs to which the issuer has offered contracts that are still pending.
4. Contingency plans for how the issuer's provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

CMS's *ECP List* and *Low-income ZIP Code List* are typically posted to the ECP page of the QHP certification website annually each Spring, before QHP application submission begins.

4.5 Network Adequacy

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1050; 45 CFR 156.230
ASSOCIATED STATE STATUTE: O.C.G.A. §33-20E-1 ET SEQ. AND RELATED RULES, AS AMENDED FROM TIME TO TIME

Georgia Access follows the network adequacy standards established by CMS, in compliance with the final *2025 Notice of Benefit and Payment Parameters (NBPP)*.

Issuers must meet a standard of "reasonable access" to providers of covered services and comply with the time and distance standards defined by CMS for a consumer to have reasonable access to a network. Issuers must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay.

To evaluate network adequacy, the State follows the baseline time and distance standards outlined in the *2023 Final Letter to Issuers in the Federally-facilitated Exchanges*, the appointment wait time standards outlined in the *2025 Final Letter to Issuers in the Federally-facilitated Exchanges*, and alternative time and distance standards and time and distance calculation methodology as referenced in the *2026 Final Letter to Issuers in the Federally-facilitated Exchanges*. In addition, the State requires issuers to adhere to the federal network adequacy standards detailed below.

1. General requirement (45 CFR 156.230(a))
    a. Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:
        i. Includes ECPs in accordance with 45 CFR 156.235.
        ii. Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay.
        iii. Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Service (PHS) Act.
2. Access to provider directory (45 CFR 156.230(b))
    a. A QHP issuer must make its provider directory for a QHP available to the State for publication online in accordance with guidance from the U.S. Department of Health and Human Services (HHS) and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.
    b. A QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations,

in a manner that is easily accessible to plan enrollees, prospective enrollees, Georgia Access, and HHS. A provider directory is easily accessible when:

i. The general public is able to view all of the current plan providers in the provider directory on the issuer's public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

ii. If an issuer maintains multiple provider networks, the general public is able to easily distinguish each provider directory and discern which providers are associated with each plan.

c. QHP and SADP issuers submit provider JSON files to Georgia Access on a recurring basis. These files are used to populate the Provider Directory search on GeorgiaAccess.gov. QHP and SADP issuers also submit the machine-readable URL inclusive of the provider JSON files, along with machine-readable technical POCs. This data is compiled into a Public Use File (PUF) and used to populate Provider Directory search functions for Enhanced Direct Enrollment (EDE) partners. The operational details of these submissions are provided during issuer onboarding with the State.

3. Provider transitions (45 CFR 156.230(d))
    a. Issuers must make a good faith effort to provide written notice of termination of a discontinued provider 30 days prior to the effective date of the change or, otherwise as soon as it is practicable, to all enrollees who are seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued. This must be done irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.
    b. To identify enrollees who are patients of a provider that is terminating, the issuer must work with the provider to obtain the list of affected patients, use its claims data system to identify enrollees who see the affected providers, or use another reasonable method.
    c. In cases where the provider is terminated without cause, the issuer must allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.
4. Out-of-network cost sharing for in-network settings (45 CFR 156.230(e))
    a. Issuers are required to count cost sharing paid by an enrollee for an Essential Health Benefit (EHB) provided by an out-of-network ancillary provider at an in-network setting towards the in-network annual limitation on cost sharing in certain circumstances.
        i. For example, if a QHP enrollee received an EHB in an in-network setting, such as an in-network hospital, but as part of the provision of the EHB the enrollee was charged out-of-network cost sharing for an EHB provided by an out-of-network ancillary provider, that cost sharing would apply towards the annual limitation on cost sharing.

Issuers that exhaust all efforts to meet network adequacy standards but are unable to do so by the State's deadlines are required to submit a justification. The State provides issuers with pre-populated justification forms to complete after reviewing issuers' initial network adequacy data submissions. At a minimum, the justifications must include:

1. The reasons that one or more standards were not met.
2. The mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types where standards were not met.
3. Information regarding enrollee complaints regarding network adequacy.

4. The issuer's efforts to recruit additional providers.

The State collects a separate data template ***that includes network adequacy data*** in July, rather than by the initial submission deadline, to provide issuers with additional time to prepare network data. However, ECP data is still due by the initial submission deadline. Issuers must submit the ECP/NA Template with ECP data by the initial submission deadline. To bypass validation errors through MPMS and SERFF, ***dummy network adequacy data will need to be provided in the NA tab*** *for the initial application submission.*

Georgia Access is also requiring issuers to submit CMS's Network Adequacy GACH List Feedback Form to the State when an issuer identifies any corrections that are needed to the Network Adequacy GACH List. See *Section 5 QHP Application Material Requirements & Submission* for the specific deadlines and submission locations for the Network Adequacy GACH List Feedback Form.

The State also provides issuers with network adequacy review results, including a pre-populated Georgia Network Adequacy Justification Form for issuers to fill out. See *Section 5 QHP Application Material Requirements & Submission* for the specific deadlines and submission locations for the network adequacy template, and the completed justification form. After justification submission, the State reviews and validates justification responses, and contacts issuers if updated justification forms and/or updated network adequacy templates are required.

4.6 Plan Design

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1020; 45 CFR PART 156 SUBPART B

QHPs must provide similar benefits, provide cost sharing, and fit within a specified metal tier level. "Metal tier level" refers to the tier of coverage (bronze, silver, gold, platinum, or catastrophic) that a QHP falls into based on its actuarial value. Issuers must also use Georgia's EHB benchmark plan when designing plans to ensure the provided coverage meets the EHB requirements. Issuers should refer to CMS's Information on EHB Benchmark Plans webpage to view Georgia's EHB benchmark plans.

4.6.1 Non-Discrimination

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.225(b)

Issuers must adhere to all non-discrimination requirements when designing their plans. Specifically:

1. Issuers must not design plan or benefit cost sharing structures that are discriminatory in nature.
2. Issuers must not design prescription drug formularies that are discriminatory in nature (e.g., requiring an unusually large number of drugs be subject to prior authorization or step therapy requirements, or not offering sufficient type and number of drugs associated with certain conditions as recommended in clinical guidelines).

4.6.2 Plan Marketing Names

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.225(c)

All issuers must offer plans and plan variations with marketing names that include correct information, without omission of material fact, and do not include content that is misleading. Issuers and their officials, employees, agents, and representatives must not misrepresent plans and their plan designs.

Issuers should reference the *Plan Marketing Name Fact Sheet* that CMS provides on the Plans & Benefits webpage of the QHP certification website to understand appropriate plan naming conventions.

QHP issuers are required to follow a standardized format when naming their plans. This standardized format requirement does not apply to SADPs, though SADPs are still required to follow federal regulations when naming plans.

At a minimum, all plan names for QHPs must include the following required elements **in the order listed:**

1. Metal Level (bronze, silver, gold, platinum, catastrophic)
2. Product Type (HMO, PPO, EPO)
3. Individual Deductible Amount
    a. Issuers with separate medical and drug deductibles should include only the individual deductible amount for the medical deductible.
4. Primary Care Copayment or Coinsurance Amount
    a. Note: If the copayment or coinsurance value for the plan is zero, the plan name must include "$0" or "0%", respectively, and should not omit this required data element.

Issuers have the option to add the following elements to the plan name above**:**

1. **Before or after the required elements above:**
    a. Marketing Name (i.e., issuer's choice of marketing terms, such as "classic," "everyday," or "simple")
    b. Network Name
2. **After the required elements above:**
    a. Adult Vision
    b. Adult Dental
    c. Specialty Care/Services

Issuers are permitted to use dollar signs ($) and percentage signs (%) in their plan names, but are not permitted to use other special characters.

Examples of acceptable plan marketing names are below:

1. Classic Standard Gold HMO $1500 $30
2. Everyday Standard Silver PPO $5000 40% Chiro
3. Gold HMO $1500 $30 Adult Vision & Fitness $15 Generic Rx

Issuers should follow this standardized naming convention while also adhering to the guidance provided in the CMS *Plan Marketing Name Fact Sheet.* This guidance from the State is in addition to, not in replacement of, the CMS guidance.

The plan marketing names used in the Plans & Benefits Template must be used throughout all of an issuer's marketing materials—issuers may not use different plan names in their SBCs, Plan Brochures, or other materials.

4.6.3 Cost Sharing Reductions (CSRs) and Plan Variations

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1030; 45 CFR 156.130; 45 CFR 156 SUBPART E

SADP issuers must complete the relevant template for this section (the Plans & Benefits Template), however, the CSR-related content outlined in this section does not apply to SADPs.

QHP issuers are required to provide cost-sharing values and basic plan variation information for each plan submission, including the deductible, Maximum Out-of-Pocket (MOOP), copay, and coinsurance values. CMS finalized the *2025 Marketplace Integrity and Affordability (MIA) Proposed Rule*, which updates the methodology to calculate the premium adjustment percentage index (PAPI), the required contribution percentage, and the maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing. On January 29, 2026, CMS published the 2027 benefit year parameters in the guidance document, Premium Adjustment Percentage, Maximum Annual Limitation on Cost

Sharing, Reduced Maximum Annual Limitation on Cast Sharing, and Required Contribution Percentage for the 2027 Benefit Year.

QHP issuers must submit three plan variations with reduced cost sharing for each silver-level QHP offered, as well as zero and limited cost sharing plan variations for all metal tier-level QHPs offered.

Issuers are required to demonstrate the following for each plan:

1. It meets Actuarial Value (AV) requirements.
2. It does not have an annual limitation on cost sharing that exceeds the permissible threshold for the specified plan variation.
3. Cost sharing for enrollees under any silver plan variation for an EHB (or non-EHB, including grandfathered plans, under the non-EHB out-of-pocket policy) does not exceed the corresponding cost sharing in the standard silver plan or any other silver plan variation of the standard silver plan with a lower AV.
4. No individual member of an enrollment group is charged more cost sharing than the maximum annual limitation on cost sharing for individuals or, as applicable, the reduced maximum annual limitation on cost sharing for individuals, as established by HHS.
5. Zero cost sharing plan variations may not have positive cost sharing for any covered EHB, either in- or out-of-network. This includes any copay, coinsurance, deductible, or application of an annual limitation on cost sharing.
6. For limited cost sharing plan variations and zero cost sharing plan variations, the cost-sharing values for a non-EHB are the same or less than the values for the non-EHB under the associated standard plan.

4.6.4 Standardized Plans & Non-Standardized Plans

The State is not requiring issuers to offer standardized plans for PY 2027 nor imposing a limit on the number of non-standardized plans an issuer may offer.

4.6.5 Health Savings Account (HSA) Eligible Plans

As of January 1, 2026, Public Law 119-21 confers HSA-eligible status to individual market QHPs offered on the Exchange (e.g., has a value of “On the Exchange” or “Both” for the QHP/Non-QHP field of the Plans & Benefits Template) at the bronze, expanded bronze and catastrophic metal levels, regardless of whether the plans satisfy the general definition of a high-deductible health plan. For such plans, no changes are needed to a plan’s deductible or MOOP values to qualify as HSA-eligible.

Georgia Access is **requiring** issuers to indicate a value of “yes” for the HSA eligible field of the Plans and Benefits template for all of the plan’s Plan Variant IDs (-00, -01, -02, -03) if the plan has a metal level of bronze, expanded bronze, or catastrophic. This will ensure that these plans will be made visible to consumers who may choose to use the HSA qualified filter during plan shopping on the Georgia Access portal.

4.7 Rates

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1000

OCI’s IPR Division conducts rate reviews and approves all rates and associated forms. IPR begins reviewing rates, underlying assumptions, and supporting data after issuers’ initial submissions are received in SERFF. IPR coordinates directly with issuers to address any rate-specific corrections or errors.

Objections or corrections related to rate filings are typically entered into SERFF in the same location as the material that was submitted. For example, objections related to the Rates Table Template are in the

binder, while objections related to the Unified Rate Review Template (URRT) are in the Rate Filing. For any SERFF correspondence in the Rate Filing that an issuer wishes to keep confidential (i.e., not public facing), the issuer must mark these items as confidential within the Rate Filing and include an affidavit of confidentiality for the State's consideration. Please note that files and information shared publicly for all issuers will not be treated as confidential, even if marked confidential and included in the affidavit. Correspondence with examiners contained in the binder is not public information and kept confidential, the above requirements apply only to the rate filings.

For QHP issuers in the individual market (i.e., not SHOP or SADP issuers), Georgia collects primary and supplemental sets of rates each year. The primary set of rates that issuers file with their initial QHP applications accounts for the reinsurance program; these rates are reviewed for use on the Exchange. The supplemental set of rates assume a hypothetical scenario of rates without reinsurance which are analyzed to determine the impact of the reinsurance program and for federal reporting for Georgia's ACA Section 1332 State Innovation Waiver.

See *Section 5.3 Rate Information* for submission deadlines and submission locations of all rate materials.

Important Filing Guidance

- All form and rate filings should be linked to the binder via the "Associate Schedule Items" tab in SERFF. This tab should show all associated forms and rate filings items, such as the URRT and the Actuarial Memorandum for ACA health and dental filings in the binders.

- O.C.G.A. § 33-24-59.34 mandates coverage for medically necessary expenses for standard fertility preservation services when medically necessary treatment for cancer, sickle cell disease, or lupus may directly or indirectly cause an impairment of fertility.

  Action Needed by Issuers: Issuers are required to itemize the estimated cost Per Member Per Month (PMPM) for this new benefit in the unredacted actuarial memorandum submitted with the PY 2027 rate filing.

- Based on prior CMS guidance, *Insurance Standards Bulletin: Plan Year 2026 Individual Market Rate Filing Instructions*, the state is requiring issuers to include in the actuarial memorandum a detailed explanation of how CSR loads for PY 2027 were determined.
  - While Georgia is not requiring issuers to file separate rates without CSR loading at this time, issuers should be prepared to do so in the future if federal policy changes.

- Based on prior CMS guidance, *Insurance Standards Bulletin: Offering of Off-Exchange-Only Plans without "CSR Loading"*, they are encouraging states to require issuers to offer plans in the individual market that will be available exclusively off-Exchange and will not include any CSR load.

  Action Needed by Issuers: Georgia encourages issuers to comply with the guidance above, and if issuers are unable to offer such plans, justification should be provided in SERFF Binder Supporting Documentation.

4.8 Prescription Drugs

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.122; 45 CFR 156.125; 45 CFR 156.225

This section regarding prescription drugs does not apply to SADPs.

Issuers must publish drug formulary lists for all QHPs. Issuers create cost-sharing values for each tier of drug benefits along with specific drugs included in the formulary. They also select the drugs that are offered at each tier level. QHP issuers' prescription drug benefits must comply with non-discrimination standards.

A QHP must cover the greater of either:

1. One drug in every United States Pharmacopeia (USP) category and class, or
2. The same number of prescription drugs in each category and class as the EHB-benchmark plan.

To be compliant with non-discrimination standards, formulary lists must be reviewed for:

1. Formulary Outliers
    a. QHPs' formulary drug lists must meet or exceed state-level and national-level threshold values.
    b. QHPs should not have an unusually high number of drugs subject to prior authorization or step therapy requirements in a particular USP category and class.
        i. The *2018 Final Letter to Issuers in the Federally-facilitated Exchanges* details the latest guidance on USP categories and classes.
2. Clinical Guideline-based Prescription Drug Coverage
    a. Issuers must ensure availability of drugs recommended by nationally recognized clinical guidelines.
    b. In some cases, issuers may be expected to make first-line therapies available without step therapy or prior authorization.
    c. The medical conditions included in the review include bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia.
3. Tier Placement of Prescription Drugs
    a. Formulary benefit designs must not assign most or all drugs in the same therapeutic class needed to treat a specific chronic, high-cost medical condition in a high cost-sharing tier.
    b. Evaluate plan coverage of drugs needed to treat medical conditions considered commonly diagnosed, chronic, and high cost.

The State permits issuers to make changes to their formularies throughout the plan year only if the change(s) receive prior approval by the Pharmacy and Therapeutics Committees referenced in 45 CFR 156.122 and are fully compliant with drug inclusion requirements of that regulation. Issuers are also expected to ensure formulary changes are consistent with EHB requirements throughout the year.

Per federal requirements, any change to the formulary having a +/- 2% impact on a plan's actuarial value constitutes a new product. As such, any change impacting a plan's actuarial value to this extent is only allowed as part of the annual QHP application submission and cannot be made during the plan year.

All individual QHP formulary information is initially loaded into the Georgia Access Eligibility System using the Prescription Drug Template that was submitted as part of issuers' QHP applications. Individual QHP issuers that receive State approval to make mid-year formulary updates have the option to submit an updated Prescription Drug Template or a formulary JSON file to the State's SFTP site.

Issuers requesting to make formulary updates must email PlanManagement@GeorgiaAccess.ga.gov with the requested change, the effective date of the change, and the format of the updated data (i.e., Prescription Drug Template or formulary JSON file). Additional details will be provided to the issuer in response to this email, including when the issuer is approved to submit their data to the State's SFTP site.

4.9 Third Party Payment of Premiums and Cost Sharing

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.1250

Issuers offering individual market QHPs and SADPs, and their downstream entities, must accept premium and cost-sharing payments made on behalf of QHP enrollees from the following third-party entities:

1. Ryan White HIV/AIDS Program under title XXVI of the PHS Act.
2. An Indian tribe, tribal organization, or urban Indian organization.
3. A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

Issuers must clearly specify for consumers whether a proposed plan accepts or refuses third-party payments.

4.10 Data Integrity

Data integrity reviews confirm that the data displayed to consumers on GeorgiaAccess.gov and EDE websites is complete and accurate and aligns with the QHP application data that was submitted by the issuer.

The State's data integrity review includes identifying critical data errors within and across templates, conducting validation checks beyond the standard SERFF checks, and looking across templates for consistency in fields that are included in multiple templates.

4.11 Mental Health Parity

ASSOCIATED FEDERAL REGULATION: 45 CFR 146.136

This section regarding mental health parity does not apply to SADPs.

The Mental Health Parity and Addiction Equity Act (MHPAEA) and Georgia Code Sections 33-24-28.1 and 33-24-29.1 impose requirements regarding mental health parity and coverage of treatment of mental disorders.

Every issuer authorized to issue accident and sickness insurance benefit plans, policies, or contracts are required to make available coverage for the treatment of mental disorders. This can be either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after 7/1/1998. The coverage must be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Additionally, the coverage cannot require more prior authorizations than for other covered benefits or create any barriers to coverage.

To demonstrate compliance with state and federal requirements, the State requires issuers to submit the Mental Health Parity Tool. This tool does not provide legal advice; rather, it gives a basic understanding of the MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, visit the U.S. Department of Labor's webpage on Mental Health and Substance Use Disorder Parity.

4.12 Plan ID Crosswalk

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.410(G)

This section regarding plan ID crosswalks does not apply to issuers that did not offer on-Exchange plans on GeorgiaAccess.gov for PY 2026.

Issuers submit their Plan ID Crosswalk Templates to SERFF for the State to review during the QHP application submission process. This template maps PY 2026 plan IDs and service area combinations to PY 2027 plan IDs. All Plan ID Crosswalk Templates must include PY 2026-certified catastrophic plans in order for these consumers to be cross walked to a new plan.

This data is used to determine which 2027 plans the individual market enrollees are auto-renewed into based on their 2026 plans. Consumers have the opportunity to change the plan they are auto-renewed into for 2027 during OE. If there are plans from the previous year that cannot be cross walked to a plan offered by the same issuer, the State determines the appropriate crosswalk into a different issuer's plan (i.e., "alternate enrollment"), when possible.

Georgia Access generally follows the alternate enrollment hierarchy established by the FFE but may deviate from this approach to consider other factors such as cost sharing or premium amounts. The FFE's hierarchy is outlined below.

1. The enrollee's coverage will be matched to a QHP at the same metal level under the same product network type.
2. If there is no QHP available at the same metal level under the same product network type in the same service area, the enrollee will be matched to a QHP at the same metal level under a different, if possible similar, product network type.
3. If no QHP is available that is the same metal level under a different product network type in the same service area, the enrollee will be matched to a QHP that is one metal level lower than the enrollee's current QHP under the same product network type.
4. If no QHP is available that is one metal level lower than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be matched to a QHP that is one metal level lower under a different, if possible similar, product network type.
5. If no QHP is available that is one metal level lower under a different product network type in the same service area, the enrollee will be matched to a QHP that is one metal level higher than the enrollee's current QHP under the same product network type. Cost is not considered a factor in alternative enrollment hierarchy.
6. If no QHP is available that is one metal level higher than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be matched to a QHP that is one metal level higher under a different, if possible similar, product network type.
7. If no QHP is available that is one metal level higher under a different product network type in the same service area, the enrollee will be matched to a QHP at any metal level under the same product network type.
8. If no QHP is available for enrollment at any metal level under the same product network type in the same service area, the enrollee will be matched to a QHP at any metal level under a different, if possible similar, product network type.

4.13 Marketing URLs

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.225

Issuers must submit marketing URLs (SBC, Plan Brochure, Payment, Formulary, and Network/Provider URLs) to the State in ShareFile via the Issuer URL Template. Issuers can obtain a copy of this template from ShareFile. All URLs must follow the below requirements:

1. URLs must lead to active webpages that contain accurate issuer marketing information for consumers upon the submission deadline in *Section 2 PY 2026 QHP Application & Certification Timeline*.
    a. URLs submitted to the State are not provided to consumers or other external parties until after URLs are approved following the URL plan validation window.
2. URLs include no inaccuracies in issuer marketing material when compared to data within an issuer's submitted QHP application.
3. Issuers' network URLs meet provider directory accessibility standards.

Issuers must follow the standardized filename format below when saving and submitting their Issuer URL Templates:

- **[HIOS Issuer ID]_[Issuer Name]_PY2027 URL Template_V1**

For any subsequent updated Issuer URL Template submissions, issuers **must update** the number after "V" to correlate to the submission version (e.g., V2, V3, etc.) and update the "Generated" date within the template to the date the template was updated.

Refer to *Appendix B: URL Review Criteria and Guidance* for more information on the State's review criteria for the marketing URLs.

4.13.1 SBC PDF Submission & Reviews

The State is requiring issuers to submit PDFs for a subset of their SBCs before the Issuer URL Template deadline, as outlined in *Section 2 PY 2026 QHP Application & Certification Timeline*. **Georgia Access will contact issuers with the specific plan variants that require SBC PDF submission at least two weeks before the SBC PDF submission deadline.**

Issuers **must use** the following standard filename format for their SBC PDFs:

- **[Plan ID]-[Variant ID]_[Issuer Name]_PY2027 SBC_V1**

For any subsequent updated SBC PDF submissions, issuers **must update** the number after "V" to correlate to the submission version (e.g., V2, V3, etc.).

Issuers are required to use CMS's SBC Template format for their SBCs. Please refer to the Summary of Benefits and Coverage and Uniform Glossary section of the CMS website for additional information, including the approved SBC Template for issuers to use when completing their SBCs.

4.13.2 Payment URLs and PayNow

Issuers provide the Payment URL in the Issuer URL template annually so that this URL is included in the PUFs provided to the public and to EDE entities. Issuers configure and set up their PayNow settings in the Georgia Access Plan Management Module for the payment redirect functionality. Returning issuers should confirm that their previous year's PayNow URL is accurate and that the certificates are up to date. New issuers configure their PayNow settings in the platform during the testing and onboarding process.

4.14 Machine-Readable URL Data

Issuers must submit a machine-readable URL and technical POC email address to the State. This information is consolidated and provided to Georgia Access EDE partners for populating their enrollment portals. Issuers should follow the standard CMS machine-readable data requirements that include the Index, Plans, Provider, and Drugs/Formulary JSON files within the single machine-readable URL. Issuers submit the Machine-readable URL and technical POC to ShareFile.

4.15 Transparency in Coverage Reporting

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1040; 45 CFR 156.220

Georgia is required to collect information relating to coverage transparency from QHP issuers. The Transparency in Coverage Template collects claims data from the most recent complete calendar year, and is submitted in the SERFF Templates section by the initial application deadline.

To meet federal requirements for making claims data public, the State also requires issuers to submit their Transparency in Coverage Template in the Forms Filing side of SERFF by the final application deadline.

Issuers also must submit, via ShareFile, a Transparency in Coverage URL to the State to demonstrate compliance with public information requirements. Refer to *Appendix B: URL Review Criteria & Guidance* for more information on the State's review criteria for the Transparency in Coverage URL.

Additionally, a QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to the individual through an Internet website or other means for individuals without access to the Internet.

4.16 Meaningful Access

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.250

A QHP issuer must provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in 45 CFR 155.205(c). This includes taking reasonable steps to ensure meaningful access to offerings and programs for individuals with Limited English Proficiency (LEP), and individuals with disabilities. This may include alternate or additional forms of notices, including taglines.

4.17 Patient Safety Standards for QHP Issuers

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.1110

This section regarding the patient safety standards does not apply to SADPs.

Issuers that contract with a hospital with more than 50 beds must verify that the hospital utilizes a patient safety evaluation system and has implemented a comprehensive, person-centered discharge program to improve care coordination and health care quality for each patient. A patient safety evaluation system is defined as the collection, management, or analysis of information for reporting to or by a Patient Safety Organization (PSO).

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital:

1. Works with a PSO, or

2. Meets the reasonable exception criteria by implementing an evidence-based initiative to improve health care quality through the collection, management, and analysis of patient safety events that reduce all cause preventable harm, prevent hospital readmission, or improve care coordination.

4.18 Quality Reporting

ASSOCIATED FEDERAL REGULATION: 45 CFR 155 SUBPART O; 45 CFR 156.1125; 45 CFR 156.1120

Quality Rating System (QRS) and QHP Enrollee Survey requirements do not apply to SADPs.

Georgia Access issuers must comply with CMS's Quality Rating System (QRS) and QHP Enrollee Experience Survey requirements. The QRS is a rating system CMS uses to assign a rating to all QHPs regardless of Exchange model. The QRS is intended to provide information about the quality of health care services and the experience of enrollees. Under the QRS, QHPs are given an overall rating on a 5-star scale, with 5 stars representing highest quality. This rating is based on 3 categories: Member Experience, Medical Care, and Plan Administration.

Georgia Access QHP issuers are required to submit quality data to CMS. This data submission requirement applies to all QHPs with more than 500 enrollees in the previous year and that have been offered in an Exchange for at least one year. Prior to OE, CMS provides the State with the quality ratings to display during plan shopping.

Section 1311(c)(4) of the ACA requires the HHS Secretary to develop an enrollee satisfaction survey system that assesses consumer experience with QHPs offered through an Exchange. It also requires public display of information by each Exchange to allow individuals to assess enrollee experience among comparable plans.

4.19 Quality Improvement Strategy

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.200; 45 CFR 156.1130

This section regarding the Quality Improvement Strategy (QIS) does not apply to SADPs.

A QHP issuer must submit a QIS Implementation Plan and Progress Report Form to the State. A QIS can address activities related to health care topic areas identified in section 1311(g)(1) of the Affordable Care Act which include: improving health outcomes, preventing hospital readmissions, improving patient safety, reducing medical errors, promoting wellness and health, and reducing health and health care disparities.

A QIS does not have to address the needs of all enrollees in an offered QHP. A QIS may address a subpopulation of a QHP's enrollee population, based on the subpopulation's identified needs.

If the State determines that a QHP has failed to meet quality requirements, the issuer must implement one or more QIS activities that apply to all of its eligible QHPs on Georgia Access.

4.20 Medical Loss Ratio

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.205(B)(1)(VI); 45 CFR 158.210

The ACA requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality. This is referred to as the MLR rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

Per federal regulations, SBEs must maintain a website that provides information on each available QHP,

including MLR information.

For PY 2027, individual market QHP issuers are required to submit MLR information by HIOS Issuer ID to the State for reporting on the Georgia Access website. MLR information is submitted through the State's ShareFile site—additional information will be provided to issuers on the submission process and format.

4.21 Stand-Alone Dental Plans

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1065

Dental coverage may be offered as an SADP or included as covered benefits within a QHP. SADPs are not required to meet the QHP certification requirements below:

1. Accreditation
2. CSRs and Plan Variations
3. Prescription Drugs
4. Mental Health Parity
5. Patient Safety Standards
6. Quality Reporting
7. Quality Improvement Strategy (QIS)

SADPs are required to comply with the following certification requirements that differ from QHPs:

Criteria	SADP Requirements
EHBs	SADP issuers have modified AV guidelines. Issuers may offer pediatric dental EHB at any AV and are not required to enter the high or low value of coverage into the template.
Cost Sharing	SADP issuers have annual limits on cost sharing with modified rates submission. Total cost sharing for EHBs should not be greater than the MOOP.
ECPs and Network Adequacy	SADP issuers have a separate list of ECPs to contract with and use the SADP ECP Tool.

5 QHP Application Material Requirements & Submission

This section includes lists of the QHP application materials required for each plan type (e.g., market type [Individual, SHOP] and product type [QHP, SADP]), the relevant deadline, the required submission location(s) for PY 2027, and outlines application submission instructions for PY 2027.

Issuers should refer to CMS's QHP Application Instructions for technical guidance when completing templates and forms provided by CMS. If there are any discrepancies between state and federal policies, issuers should defer to state policy. In this section, "QHP" in the "Plan Type" column refers to medical plans and **is not** inclusive of SADPs.

5.1 QHP Application Templates & Required Forms

The table below lists the QHP application templates and required forms for submission. Materials provided by CMS are linked to the webpage where the material can be downloaded. Issuers are encouraged to check for updates to CMS templates throughout QHP certification.

QHP Template/Required Form	State Deadline	Plan Type	Submission Location
Accreditation Certificate	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Actuarial Value (AV) Screenshot (AV Calculator available here)	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation

QHP Template/Required Form	State Deadline	Plan Type	Submission Location
Business Rules Template	5/28/2026	All	SERFF Binder Templates
ECP/NA Template – ***ECP data only (NA data not required)***[3]	5/28/2026	All	SERFF Binder Templates
Georgia Network Adequacy Template *with NA data for* ***PY 2027 QHP Certification*** *and* ***PY 2026 quarterly submission***	7/1/2026	On and Off-Exchange QHPs (Individual and SHOP) and SADPs	SERFF Binder Supporting Documentation *(PY 2027 Binder)*
Georgia ACA Checklist (can be downloaded from SERFF under the General Instructions)	5/28/2026	All	SERFF Form or Rate/Form Filing *(no longer needed in Binder)*
MLR Information	9/3/2026	Individual QHPs	State Issued Survey will be provided
Network Adequacy GACH List Feedback Form	7/1/2026	Individual & SHOP QHPs and on-Exchange SADPs	SERFF Binder Supporting Documentation
Network ID Template	5/28/2026	All	SERFF Binder Templates
Plan ID Crosswalk Template	5/28/2026	PY 2026-Certified On-Exchange Individual QHPs & SADPs	SERFF Binder Supporting Documentation
Plans & Benefits Template (the Add-In is required to populate and save template)	5/28/2026	All	SERFF Binder Templates
Prescription Drug Template	5/28/2026	Individual & SHOP QHPs	SERFF Binder Templates
QIS Form	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation & MPMS
Subset of SBC PDFs *(specific plan variants will be provided to issuers at least 2 weeks before deadline)*	8/20/2026	Individual QHPs	State ShareFile
Service Area Template	5/28/2026	All	SERFF Binder Templates
State Based Exchange Issuer Program Attestation Response Form (can be downloaded from SERFF)	5/28/2026	All	SERFF Binder Supporting Documentation
Transparency in Coverage Template[4]	5/28/2026	All	SERFF Binder Templates
	8/6/2026	All	SERFF Form Filings
Form Filings for QHPs	5/28/2026	All	SERFF Form Filings

[3] *CMS's Network Adequacy Template will show the ECP tabs once "GA" is selected from the State dropdown within the template.*

[4] *Transparency in Coverage Templates must be submitted in the SERFF Plan Management Templates as part of issuers' QHP applications by the initial application deadline. Issuers post their Transparency in Coverage Templates in the Forms Filing side of SERFF by the final application deadline to meet federal regulations to make this data public.*

5.2 Supporting Documentation and Justification Forms

The supporting documentation and justification forms below are only submitted by issuers if needed.

Supporting Document/Justification Form	State Deadline	Plan Type	Submission Location
Non-Discrimination Cost-Sharing: Supporting Documentation and Justification	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Unique Plan Design—Supporting Documentation and Justification	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification: Non-Discrimination Clinical Appropriateness	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification: Non-Discrimination Formulary Outlier	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification: Category/Class Benchmark Count	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Discrimination—Treatment Protocol Supporting Documentation and Justification	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Adverse Tiering Supporting Documentation and Justification	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation
Service Area Partial County Supplemental Response	5/28/2026	All	SERFF Binder Supporting Documentation
ECP Justification	5/28/2026	All	SERFF Binder Supporting Documentation
NA Justification Form	8/24/2026	All	SERFF Binder Supporting Documentation
Mental Health Parity Tool (provided by the U.S. Department of Labor)	5/28/2026	Individual & SHOP QHPs	SERFF Binder Supporting Documentation

5.3 Rate Information

The tables below list the required rate materials for submission. There are three tables, one for each plan type: Individual Market QHPs, SHOP QHPs, and all SADPs. The materials and submission deadlines are subject to change.

All form and rate filings should be linked to the binder via the “Associate Schedule Items” tab in SERFF. This tab should show all associated forms and rate filing items, such as the URRT and the Actuarial Memorandum for ACA health and dental filings in the binders.

5.3.1 Individual Market QHPs

Rate Material	State Deadline	Submission Location
WITH Reinsurance		
Rates Table Template(s)	5/28/2026	Required: SERFF Binder Templates Tab Optional: SERFF Rate Filings (Rate/Rule Schedule Tab)
URRT	5/28/2026	SERFF Rate Filings (URRT Tab)
Actuarial Memo, including redacted version	5/28/2026	SERFF Rate Filings (URRT Tab) (*no longer needed in Rate Filing Supporting Documentation Tab)*
Narrative Justification, if applicable	5/28/2026	SERFF Rate Filings (URRT Tab)
Georgia LH-T1 Rate Transmittal Form	5/28/2026	SERFF Rate Filings (Supporting Documentation Tab) *(no longer needed in Binder)*
WITHOUT Reinsurance		
Rates Table Template(s)	7/30/2026	SERFF Binder Supporting Documentation
URRT	7/30/2026	SERFF Binder Supporting Documentation
Supplemental Summary Sheet for Rates without Reinsurance	7/30/2026	SERFF Binder Supporting Documentation

5.3.2 SHOP QHPs

Rate Material	State Deadline	Submission Location
Rates Table Template(s)	5/28/2026	Required: SERFF Binder Templates Tab Optional: SERFF Rate Filings (Rate/Rule Schedule Tab)
URRT	5/28/2026	SERFF Rate Filings (URRT Tab)
Actuarial Memo, including redacted version	5/28/2026	SERFF Rate Filings (URRT Tab) (*no longer needed in Rate Filing Supporting Documentation Tab)*
Narrative Justification, if applicable	5/28/2026	SERFF Rate Filings (URRT Tab)
Georgia LH-T1 Rate Transmittal Form	5/28/2026	SERFF Rate Filings (Supporting Documentation Tab) *(no longer needed in Binder)*

5.3.3 SADPs

Rate Material	State Deadline	Submission Location
Rates Table Template(s)	5/28/2026	Required: SERFF Binder Templates Tab Optional: SERFF Rate Filings (Rate/Rule Schedule Tab)
Actuarial Memo	5/28/2026	SERFF Rate Filings (Supporting Documentation Tab)
Georgia LH-T1 Rate Transmittal Form	5/28/2026	SERFF Rate Filings (Supporting Documentation Tab) *(no longer needed in Binder)*

5.4 URLs and JSON Files

The below table lists the required URLs and standalone JSON files for submission. The Transparency in Coverage URL and the five marketing URLs—SBC, Plan Brochure, Network, Payment, and Formulary—are required to lead to live and active webpages on the dates outlined in the table below. The Provider JSON file submission is a standalone JSON file (not a URL) and should include PY 2027 provider information by the deadline listed.

Refer to *Appendix B: URL Review Criteria & Guidance* for more information on the State's review criteria for the Transparency in Coverage and Marketing URLs.

A blank Issuer URL Template may be downloaded from ShareFile or from SERFF General Instructions tab.

URL/JSON File	State Deadline	Plan Type	Submission Location
Transparency in Coverage URL	5/28/2026	Individual & SHOP QHPs and on-Exchange SADPs	State ShareFile
Provider JSON File for PY 2027	9/1/2026	Individual & SHOP QHPs and on-Exchange SADPs	State SFTP Site
SBC URL (Issuer URL Template)	9/3/2026	Individual & SHOP QHPs	State ShareFile
Plan Brochure URL (Issuer URL Template)	9/3/2026	Individual & SHOP QHPs and on-Exchange SADPs	State ShareFile
Network URL (Issuer URL Template)	9/3/2026	Individual & SHOP QHPs and on-Exchange SADPs	State ShareFile
Payment URL (Issuer URL Template)	9/3/2026	Individual & SHOP QHPs and on-Exchange SADPs	State ShareFile
Formulary URL (Issuer URL Template)	9/3/2026	Individual & SHOP QHPs	State ShareFile
Machine-Readable Index URL and Technical POC	9/3/2026	Individual QHPs and on-Exchange SADPs	State ShareFile

5.5 Application Submission

Issuers must submit their QHP applications via SERFF on the timeline outlined in *Section 2 PY 2025 QHP Application & Certification Timeline*. The State coordinates with the National Association of Insurance Commissioners (NAIC) annually to configure SERFF to accommodate any state-specific requirements related to application material collection. Additionally, several supplemental QHP application materials are collected via ShareFile as outlined in the previous section.

Issuers should refer to the "Filing Rules" tab of SERFF for instructions on Georgia forms filing. All related form and rate filings for each QHP must be linked to the Plan Management binder, so that the form filings and rate documents appear in the "Associate Schedule Items" tab of the binder in SERFF.

5.5.1 MPMS Module Application Creation and Plan Validation Workspace

Georgia issuers must also use the MPMS Plan Validation Workspace, as their templates are readied, to identify and resolve validation and cross validation errors and warnings before submitting application data in SERFF. While these validation and cross validation *errors* are also present through SERFF Validate & Transform, issuers are required to use the Plan Validation Workspace to identify validation and cross validation *warnings*, which are unexpected conditions in issuers' data, and review prior to submitting data in SERFF. Using this functionality before submitting to the State in SERFF also helps prevent issuers from running into any unexpected submission-blocking errors when submitting in SERFF.

The State has access to issuers' Plan Validation Workspaces in MPMS and confirms that issuers complete this requirement. To view a list of all validation checks conducted for SBEs, issuers should download the applicable plan year's *MPMS Validations List* from CMS's QHP certification website's Data Validation webpage and filter the various tabs' "Applicable State Exchange Model" columns to display only the validations that include "SBE".

CMS also provides Excel-based review tools that issuers and states may use to check for errors within their QHP application data. Issuers are welcome to use these review tools to identify and resolve errors prior to using the Plan Validation Workspace, but it is not a requirement. The State runs the CMS tools on all issuers' QHP application data as part of QHP certification reviews.

5.6 State Reviews and Issuer Corrections

The State begins reviewing all QHP application data as plans are submitted in SERFF. As a part of these reviews, the State logs into MPMS to confirm that issuers have completed all Plan Validation Workspace validation and cross validation checks. The State notifies issuers of corrections needed or missing data in their application via objections in SERFF. Issuers may also receive emails from PlanManagement@GeorgiaAccess.ga.gov or their assigned examiner with required corrections for their applications.

Issuers are expected to be communicative throughout the QHP application review period, and to promptly make changes to their application data based on the State's feedback. Delayed responses to the State and examiners may result in missing deadlines, which could impact certification decisions.

6 Plan Withdrawals

Between the initial application deadline and the withdrawal deadline, issuers can request to withdraw plans as needed for the upcoming plan year. Issuers must submit the *Georgia Access PY 2027 Plan Withdrawal Notification Form* in ShareFile by the withdrawal deadline.

Issuers can also change the status of SADPs to off-Exchange only by this deadline. The State reviews and approves/denies withdrawal requests on a case-by-case basis and coordinates with issuers accordingly. Any plan withdrawals will be approved or denied by the State's final application deadline.

If the request is approved, issuers **should not** remove withdrawn plans from their QHP application templates, with the exception of the URRT and the Plan ID Crosswalk Template. The State will not mark withdrawn plans as "Certified" in SERFF, preventing these plans from being transferred to the Georgia Access Plan Management Module or included in the PUFs.

If an issuer with PY 2026-certified plans discontinues all QHPs in Georgia's individual health insurance market for PY 2027, the issuer may not be permitted to return to offer plans for a period of five years beginning on the date of discontinuation of the last coverage not renewed.[5]

7 Plan Validation & Certification

7.1 Plan Validation

Issuers must conduct plan validation to review plan data in the Georgia Access Plan Management Module and confirm that the plan data is accurate and displayed correctly for consumers. The timeline for issuers to conduct initial plan validation and URL plan validation is outlined in *Section 2 PY 2026 QHP Application Submission & Certification Timeline*.

Issuers receive further guidance from the State on completing plan validation in August. This guidance includes the basic data elements to check and the process for completing required activities.

[5] *https://www.ecfr.gov/current/title-45/part-147/section-147.106#p-147.106(d)(2)*

The State and issuers must coordinate to reconcile any data errors found during plan validation and reload data in the Georgia Access Plan Management Module. For any data errors, issuers should follow the data correction process described in *Section 8 Data Changes*, unless directed otherwise.

7.2 Certification Notices

The State uploads Certification Notices to issuers individual folders in ShareFile; the document includes a list of plans that have been certified. An email notification is sent to issuers when certification notices are available in ShareFile and decisions are marked in SERFF. All issuers must confirm receipt of the Certification Notice.

All plan certification decisions made by Georgia Access for the upcoming plan year are final. Issuers may not appeal the State's certification determination. The State reserves the right to identify and communicate required plan data corrections prior to and after certification based on the original QHP application and any changes made to the application.

8 Data Changes

The approach for issuers making QHP application data changes depends upon where issuers are in the application submission and review process. This section provides the guidelines for issuers to submit a data change, including the parameters under which issuers may change their submitted QHP data and the steps to submit a data change request.

8.1 Timeline for Acceptable QHP Data Changes

The below outlines the allowable data changes and change process for each stage of the QHP application process.

1. **Before Initial Application Deadline**
    a. *Allowable Data Changes:* Issuers may make any changes to their data in SERFF without State authorization. Issuers may also remove or add plans and may change plan types without State authorization.
    b. *Data Change Process:* None.
2. **After Initial Application Deadline and before Final Application Deadline**
    a. *Allowable Data Changes:* Issuers work closely with the State and examiners to make data corrections to applications if errors are identified by the issuer or if instructed by the State or the examiners. Issuers may not add new plans for QHP certification consideration. 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.
    b. *Data Change Process:* Issuers do not need to submit a *Georgia Access QHP Data Change Request Form*, but they must notify the State and their examiner in SERFF or via PlanManagement@GeorgiaAccess.ga.gov of any changes made to QHP applications to ensure the State is reviewing the most updated version(s). Some examples may include, but are not limited to:
        i. A change in service area.
        ii. Any updates to cost-sharing information and benefit limit explanations.
        iii. A change in plan marketing names.
3. **After Final Application Deadline and before Plan Certification Notices Are Sent**
    a. *Allowable Data Changes:* Issuers may only make data changes if instructed to do so by the State. If issuers identify data errors—either through plan validation or

otherwise— they must notify the State of the error. Issuers may not add new plans for QHP certification consideration. 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.

b. *Data Change Process:* The State may direct issuers to make data changes as a result of plan validation findings—identified by either the issuer or State. The State may request that issuers submit a *Georgia Access QHP Data Change Request Form* or may instruct issuers to make the changes directly in SERFF. For approved data changes, issuers make changes in SERFF and notify PlanManagement@GeorgiaAccess.ga.gov once changes are complete. The State reviews the changes and if approved, transfers the updated data to the Georgia Access Plan Management Module, and the State and issuer to continue plan validation, if applicable.

4. **After Plan Certification Notices Are Sent**
   a. *Allowable Data Changes:* Issuers may not change QHP data without the explicit direction and authorization of the State. Issuers may only make data corrections to their QHP application as required by the State's final application review or with an approved data change request.
   b. *Data Change Process:* Data change requests are required for all data changes via the *Georgia Access QHP Data Change Request Form* unless otherwise directed by the State. Refer to *Section 8.2 Data Change Request Process Post-Certification* for more details.

8.2 Data Change Request Process Post-Certification

After plan certification, there may be a limited, rare need for issuers to make changes to their plan data, primarily including requests to change data based on errors identified in the certified plan data. The process below outlines the steps to request, obtain approval for, and make data changes post-certification.

1. The issuer completes and submits the *Georgia Access QHP Data Change Request Form* to Georgia Access in ShareFile.
2. The State receives the change request, reviews the information provided, and decides whether the request is approved.
3. The State communicates the final decision to the issuer from PlanManagement@GeorgiaAccess.ga.gov. If the request is denied, the issuer may resubmit the request addressing any issues identified by the State.
4. The State opens the issuer's binder in SERFF to allow the issuer to make changes.
5. The issuer makes the change in the relevant template(s) and/or supplemental documentation and submits the updated materials in SERFF.
6. The State conducts a review of the changes that the issuer submitted to SERFF, and coordinates with the issuer to make additional changes, if needed.
7. The State closes the binder in SERFF.
8. If the changes impact plan display, the State transfers the updated plan(s) from SERFF to the Georgia Access Plan Management Module, reviews to confirm the data transferred appropriately, and marks the plan as "Certified" in the Georgia Access Plan Management Module. The issuer reviews and marks the plan(s) as "Verified," as they did during the plan validation process.
9. If the changes require any updates to PUF data, the State regenerates the relevant PUF(s), uploads them to ShareFile, posts them to GeorgiaAccess.gov (if the changes are after the initial PUFs have been posted), and notifies Georgia Access EDE partners of the updates.

The table below provides examples of allowable/unallowable data changes post-certification.

Criteria for Allowable Changes	Criteria for Unallowable Changes
Examples of changes that the State would consider approving are: 1. Changes that do not alter the QHP's certification status or require extensive re-review of data previously approved by the State; 2. Changes to plan or plan variant marketing names (only in cases that would reduce consumer confusion); 3. Minor changes to cost-sharing information and benefit limits explanations; and 4. Exchange-requested data corrections.	Examples of changes that the State would not consider approving are: 1. Changes that may lead to inaccuracies and/or the incompleteness of a QHP application; 2. Changes that do not remain in compliance with all certification standards, including non-discrimination and CSR requirements; 3. Changes to individual market rates, service areas, or EHB percent of total premium unless the issuer can demonstrate specific critical issues resulting from data errors; and 4. Changes that negatively impact a consumer and/or enrollees.[6]

9 Ongoing Monitoring & Compliance

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1010; 45 CFR 155.1200, 45 CFR 155.1080

The State performs compliance reviews throughout the year to monitor issuer compliance with applicable Exchange-specific requirements and operational standards. These compliance reviews may be based on ad hoc topics selected by the State or complaints submitted to the State. Issuers may be notified of their selection for these compliance reviews at any time during the year.

Issuers participating in Georgia Access agree to adhere to all QHP certification regulations within the BAA, which also requires issuers to cooperate with any compliance reviews conducted by the State. Issuers should also reference the BAA for specific requirements related to complying with QHP standards. Please refer to *Section 12 Issuer Business Associate Agreement* for more information on issuer BAAs.

The following sub-sections provide guidance on issuer compliance monitoring, reviews, and participation throughout the plan year.

9.1 Complaint-Driven Compliance Reviews

The State conducts complaint-driven compliance reviews on issuers participating in Georgia Access. The review process is initiated in response to a formal or informal complaint filed by any individual, consumer, or employer who becomes aware of a compliance issue. Some data sources include, but are not limited to:

1. Complaint data.
2. Issuer self-reporting.
3. Issuer policies, procedures, and operations.
4. Indicators of customer service and satisfaction.

The State compiles any relevant data sources, such as QHP application and consumer enrollment data, and performs the compliance review. OCI's Legal Division is involved in the process as needed to follow

[6] *In extenuating circumstances, a change that negatively impacts consumers may be approved. In these cases, the issuer will be required to honor the benefit as it was originally displayed to existing consumers, or existing consumers will be offered an opportunity to change plans in a Special Enrollment Period (SEP).*

established protocols and procedures to maintain integrity of the review. The State coordinates with issuers throughout the review process to provide transparency and institutes a corrective action plan if needed. Georgia Access has the discretion to inform state offices including OCI's Criminal Investigations Division.

9.2 Quarterly Network Adequacy Reviews

The State collects network adequacy data on a quarterly basis for ongoing monitoring. The quarterly data collection deadlines will be set to January, April, July, and October annually to evaluate each issuers continued compliance with network adequacy standards for the current plan year.

The July network adequacy data submission is used for PY 2027 QHP certification consideration and to meet the PY 2026 quarterly review submission. Issuers with changes to their service areas for PY 2027 will need to account for those changes in the July submission of the network adequacy template. For example, if an issuer is expanding their service areas, the July submission should include both current PY 2026 provider networks, as of 6/17/2026, and providers that the issuer is projected to contract with in PY 2027 for the expansion areas in the same network adequacy data template. The "Plan Year" column is used to differentiate between current networks and network projections. The template is submitted to SERFF in an issuer's binder for PY 2027 QHP certification on the "Supporting Documentation" tab. The State communicates specific deadlines with issuers after certification each year.

The State may contact the issuer for further discussion or clarification based on the review of the quarterly network adequacy data submissions.

9.3 Decertification

If an issuer is no longer in compliance with Georgia Access QHP certification requirements, and the State deems that the compliance issue cannot be corrected, one or more of the issuer's plans may be decertified. Decertification can only occur after the plan has already been certified by Georgia Access for that plan year. If a plan with consumer enrollment is decertified, affected enrollees are granted an SEP to select a new plan. Decertification is generally a measure of last resort if all other corrective measures have been applied and have failed to resolve the compliance issue.

Georgia Access may decertify a plan for failure to comply with any QHP certification criteria, including, but not limited to, the following:

1. Loss of valid issuer license as issued by OCI.
2. Financial insolvency.
3. Loss of network providers so that the plan no longer meets the network adequacy standards for QHP certification.

In the event of decertification, the State updates PUFs and sends appropriate notices to affected issuers and Georgia Access EDE partners to confirm next steps on decertifying the plan(s) and removing them from display on all enrollment portals.

9.3.1 Decertification Appeals Process

If a plan is decertified due to failure to comply with certification criteria, issuers may submit a written appeal within 15 calendar days to PlanManagement@GeorgiaAccess.ga.gov. The State reviews the appeal and accompanying documentation to make a determination. The State notifies the issuer of the appeal decision.

Issuers that disagree with an appeal decision have the right to escalate the decertification appeal to the Administrative Procedure Division (APD) within OCI.

9.4 Plan Suppression

The State suppresses all decertified plans from display on the Georgia Access consumer portal, so that consumers do not have access to the plan during plan shopping and cannot select the plan for enrollment.

The State may also temporarily suppress a plan from display if the plan is found to have critical data errors or other issues that cause consumer confusion or harm, and will only un-suppress these plans once the data errors have been corrected. Temporary suppressions are generally not used as a method of controlling, capping, or limiting enrollment in a certain plan, but are used to protect consumers from data errors. The State notifies issuers of any plan suppressions and plan un-suppressions before they occur.

The State also communicates all plan suppressions and un-suppressions to Georgia Access EDE partners to ensure the plans displayed across all Georgia Access enrollment platforms are aligned.

10 Small Business Health Options Program

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.286

Georgia Access operates the State's SHOP to support qualified employers with providing health insurance coverage to their employees. SHOP plans must be filed as "on-Exchange" small group plans and must adhere to the individual market QHP certification standards. The State does not transfer SHOP plans to the Georgia Access Eligibility System or display plan information for SHOP through the Georgia Access consumer portal or web broker sites. The State directs small employers to contact SHOP issuers and/or Georgia Access certified agents directly to assist with plan-specific and member-level matters, including renewal timelines, payments, and employee enrollment.

More information about SHOP is publicly available on the Options for Small Businesses webpage of the Georgia Access website. Issuers may contact SHOP@GeorgiaAccess.ga.gov with any SHOP-related inquires. Employers and Georgia Access certified agents may also use this email address to contact Georgia Access SHOP.

11 User Fees for PY 2027

Georgia is working to finalize the user fee rate for PY 2027 and will notify issuers once available.

For questions about retrieving Georgia Access invoices and submitting payments:

1. Email: intake@georgiaaccess.ga.gov.
2. Call: 404-656-2070 or 1-800-656-2298

12 Issuer Business Associate Agreements

All new and returning issuers with plans displayed on Georgia Access must sign an Issuer BAA annually and submit it to the State to participate in Georgia Access for PY 2027. The State will provide issuers with separate instructions and deadlines for signing and submitting the BAA.

This agreement sets forth the expectations of Georgia Access and issuers with respect to:

1. The delivery of services and benefits to customers.
2. The respective roles related to enrollment, eligibility, and customer service for customers.
3. Coordination and cooperation to promote quality, high value care for customers.
4. Administrative, financial, and reporting relationships and agreements.

5. Privacy and security standards.

Please note that SHOP-only issuers do not sign the Issuer BAA.

Appendix A: Resources

The sections below provide a consolidated list of resources that are noted within the document.

Georgia Access Resources

The following lists the Georgia Access resources for reference:

1. Georgia Access Website: www.GeorgiaAccess.gov
2. Georgia Access Issuer Policy Manual: https://georgiaaccess.gov/about-georgia-access/policies/

Georgia Access Email Inboxes

The following lists the Georgia Access email inboxes for reference:

1. Georgia Access Plan Management Inbox: PlanManagement@GeorgiaAccess.ga.gov
2. Georgia Access SHOP Inbox: SHOP@GeorgiaAccess.ga.gov

Federal Government Resources

The following lists the federal government resources for reference:

1. SERFF Access: https://www.serff.com/serff_getting_started.htm
2. HIOS MPMS Access: *CMS's HIOS Quick Reference Guide* and *MPMS Module User Guide* on the Submission Systems webpage (https://www.qhpcertification.cms.gov/s/Submission%20Systems).
3. 2023 Letter to Issuers in the FFE: https://www.cms.gov/sites/default/files/2022-04/Final-2023-Letter-to-Issuers_0.pdf
4. 2025 Letter to Issuers in the FFE: https://www.cms.gov/files/document/2025-letter-issuers.pdf
5. 2026 Letter to Issuers in the FFE: https://www.cms.gov/files/document/final-2026-letter-issuers.pdf
6. 2027 Letter to Issuers in the FFE (Draft): https://www.cms.gov/files/document/draft-2027-letter-issuers.pdf
7. 2025 Notice of Benefit & Payment Parameters: https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf
8. 2026 Notice of Benefit & Payment Parameters: https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf
9. 2027 Notice of Benefit & Payment Parameters (Proposed): https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf
10. CMS Plan Marketing Name Fact Sheet (Plans and Benefits webpage): https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits
11. Mental Health Parity and Addiction Equity Act (MHPAEA): https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
12. Federal Regulation for Market Withdrawal Exception to Guaranteed Renewability Requirements: https://www.ecfr.gov/current/title-45/part-147/section-147.106#p-147.106(d)(2)
13. CMS QHP Website: https://www.qhpcertification.cms.gov/s/QHP
14. CMS QHP Application Materials: https://www.qhpcertification.cms.gov/s/Application%20Materials
15. CMS's QHP Application Instructions: https://www.qhpcertification.cms.gov/s/Application%20Instructions

16. CMS's Review Tools: https://www.qhpcertification.cms.gov/s/Review%20Tools

Appendix B: URL Review Criteria & Guidance

Issuers are required to submit a Transparency in Coverage URL and the five marketing URLs—SBC, Plan Brochure, Network, Payment, and Formulary—to the State for review. The list below provides an overview of the review criteria and any other guidance for issuers to consider when submitting URLs to the State.

Transparency in Coverage URL

This URL leads to a website hosted by the issuer containing transparency in coverage information, including claims payment policies and practices and cost sharing and payments with respect to any out-of-network coverage. Issuers should follow the below criteria when preparing their Transparency in Coverage URL:

1. User Access & Current Information
    a. The URL and respective information are for this upcoming plan year.
    b. The URL leads to a website that is clearly titled to contain information on "Transparency in Coverage."
    c. The URL's web address is on the issuer's website and directs consumers to a page displaying pertinent information about issuer Transparency in Coverage practices.
    d. URLs are live and active when submitted and lead to a single page or a landing page with one or more links providing the information.
    e. The URL leads to a website that can be clearly identified on the issuer's home page or Marketplace plan landing page without requiring logging into an account or entering a policy number.
    f. A consumer can reasonably and easily discern which information applies to each plan the issuer offers if information for multiple plans is present.
2. Claims Information
    a. The URL contains information on how an enrollee can submit a claim instead of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, it must be indicated here.
    b. The URL specifies a time limit to submit a claim, if applicable. If the webpage indicates that the time limit varies for Georgia compared to other states, the corresponding time limit must be listed.
    c. The URL contains links to any applicable claim forms. All claim forms must be easily identifiable and publicly accessible.
    d. The URL describes how an enrollee can submit a claim if forms are not required. Any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission is listed.
    e. The URL contains the physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number.
3. Grace Periods & Payments
    a. The URL explains what the grace period is, including the duration, and clearly states the difference between a standard grace period and grace periods for consumers receiving PTCs.
    b. The URL explains claims pending; a variation of the phrase "pending" or "to pend" must be used in the definition.
    c. The URL explains that issuers pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

4. Denials & Overpayments
    a. The URL explains that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
    b. The URL lists methods to prevent retroactive denials when possible, such as paying premiums on time.
    c. The URL contains instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact.
5. Prior Authorizations
    a. The URL explains that some services may require prior authorization and may be subject to review for medical necessity.
    b. The URL explains ramifications or consequences should the enrollee not follow proper prior authorization procedures.
    c. The URL provides a timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable.
6. Drug Exceptions Timeframes
    a. The URL explains the internal exceptions process for people to obtain non-formulary drugs, including how a consumer would request an expedited review versus a standard review.
    b. The URL explains external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or Independent Review Organization (IRO).
    c. The URL provides timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances.
    d. The URL provides instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact.
7. Explanation of Benefits (EOB) and Coordination of Benefits (COB)
    a. The URL defines an EOB.
    b. The URL provides information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims).
    c. The URL explains to the consumer how to read an EOB and understand payments made or not made by the issuer.
    d. The URL explains COB (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

SBC URL

This URL provides a document in an industry-standard format for consumers to review plan-specific information on benefits and coverage included in a QHP. The information in the SBC is also submitted to the State via the Plans & Benefits Template. Issuers should follow the below criteria when preparing their SBC URLs:

1. An SBC URL is submitted for all plan variants for PY 2027.
2. The SBC URL leads directly to an active SBC upon submission. SBC URLs should end with a ".PDF" and lead directly to the SBC, rather than another webpage.
3. The SBC is properly formatted, matching CMS's template[7].

[7] *For more information on the SBC template, reviewers should refer to CMS's Summary of Benefits and Coverage Template and Uniform Glossary.*

4. All data fields within the SBC URL are consistent with their data in the Plans & Benefits Template. For example, the in-network (Tier 1 and Tier 2) and out-of-network cost sharing data within the SBC should be validated against the issuer-submitted Plans & Benefits Template. See the table below to understand how some data fields from the SBC are mapped to the Plans & Benefits Template. For more guidance on completing the SBC, reference the *QHP URL Reviews Checklist* on the URLs webpage of CMS's QHP certification website.

SBC's Common Medical Event to Plans & Benefits Template Mapping		
Common Medical Event	**SBC Template Field Name**	**P&B Template Field Name**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visit to Treat an Injury or Illness
	Specialist visit	Specialist Visit
	Preventative care/screening/immunization	Preventative Care/Screening/Immunization
If you have a test	Diagnostic test (x-ray, blood work)	X-rays and Diagnostic Imaging
	Imaging (CT/PET scans, MRIs)	Imaging (CT/PET Scans, MRIs)
If you need drugs to treat your illness or condition	Generic Drugs	Generic Drugs
	Preferred brand drugs	Preferred Brand Drugs
	Non-preferred brand drugs	Non-preferred Brand Drugs
	Specialty drugs	Specialty Drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
	Physician/surgeon fees	Outpatient Surgery Physician/Surgical Services
If you need immediate medical attention	Emergency room care	Emergency Room Services
	Emergency medical transportation	Emergency Transportation/Ambulance
	Urgent care	Urgent Care Centers or Facilities
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient Hospital Services (e.g., Hospital Stay)
	Physician/surgeon fees	Inpatient Physician and Surgical Services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral Health Outpatient Services
	Inpatient services	Mental/Behavioral Health Inpatient Services
If you are pregnant	Office visits	Prenatal and Postnatal Care
	Childbirth/delivery **professional** services	N/A
	Childbirth/delivery **facility** services	Delivery and All Inpatient Services for Maternity Care
If you need help recovering or have other special health needs	Home health care	Home Health Care Services
	Rehabilitation services	Outpatient Rehabilitation Services
	Habilitation services	Habilitation Services
	Skilled nursing care	Skilled Nursing Facility (Private Duty Nursing—KS issuers only)
	Durable medical equipment	Durable Medical Equipment
	Hospice services	Hospice Services

SBC's Common Medical Event to Plans & Benefits Template Mapping		
Common Medical Event	**SBC Template Field Name**	**P&B Template Field Name**
If your child needs dental or eye care	Children's eye exam	Routine Eye Exam for Children
	Children's eyeglasses	Eyeglasses for Children
	Children's dental check-up	Dental Check-Up for Children

Note: For PY 2027, the State is requiring issuers to submit PDF versions for a subset of their SBCs ahead of the URL submission deadline for review. Please refer to *Section 4.13 Marketing URLs* for more information on SBC PDF submissions, including the standard naming convention.

Plan Brochure URL

This URL typically leads to a marketing brochure for potential and current enrollees to understand, at a high level, the types of coverage their health insurance plan offers. Issuers should follow the below criteria when preparing their plan brochures and plan brochure URLs:

1. A plan brochure URL is submitted for all plan IDs for PY 2027 (plan brochure URLs are optional, but the State will check that a plan brochure URL was submitted for every plan ID, and if not, confirm with the issuer whether that was intended).
2. If a plan year/benefit year is present, the year is 2027.
3. The plan brochure includes information on how a consumer can receive language assistance.
4. The plan brochure is intended for Marketplace plans, and not other types of coverage like Medicare, large group, or off-Exchange plans.
5. Any Georgia Access branding is used appropriately and there are not unnecessary references to HealthCare.gov, the FFE/FFM, or HHS.

Network (or Provider Directory) URL

This URL contains a comprehensive list of the in-network medical providers and facilities for specific QHPs. It typically provides search functionality for enrollees to better understand options for in-network services. Issuers should follow the below criteria when preparing their network URLs:

1. A network URL is submitted for all network IDs for PY 2027.
2. Issuers with multiple provider networks clearly denote which providers participate in which plans and networks.
3. The URL is a direct link to the provider directory with no required login.
    e. **Note:** When possible, issuers should provide separate URLs for plans with differing networks. This may include different URLs for different product types (PPO/HMO) or different network IDs. For example, the URL for a PPO plan should take users directly to a page showing the PPO network, rather than a general network page that requires consumers to filter by product type.
4. The provider directory:
    a. Is up to date for PY 2027.
    b. Provides contact information for each provider listed.
    c. Provides the specialty of each provider listed.
    d. Indicates whether each provider listed is accepting new patients.
    e. Indicates whether each provider is in-network for a given plan.

Formulary URL

This URL contains the list of prescription drugs covered by a specific QHP and must specify which medications are approved for coverage and classifies them into tiers based on cost and preferred status.

The formulary URL is only applicable to medical QHPs. Issuers should follow the below criteria when preparing their formulary URLs:

1. A formulary URL is submitted for all formulary IDs for PY 2027.
2. The URL is a direct link to formulary webpage with no required login.
3. Issuers with multiple formularies clearly show which formulary applies to which QHP(s).
4. The formulary webpage:
    a. Is for PY 2027 if a plan year is mentioned.
    b. Specifies when the formulary was last updated and includes no data earlier than 2025.
    c. Clearly indicates whether a drug is covered for a particular plan.

Payment URL

This URL is used to facilitate consumer binder payments (the first month's premium) to effectuate a consumer's QHP coverage upon plan enrollment. Payment URLs are submitted and validated within the Georgia Access Plan Management Module.