Appendix A – Comments and Responses for Information Collection Requirements Related to Annual Eligibility Redetermination, Product Discontinuance and Renewal Notices (CMS-10527)

Comment: Several commenters raised concerns about providing accurate and complete information to individuals about their coverage and recommended the notices serve as model notices (rather than standard notices) that issuers could customize as along as the notices contain the essential information.

Response: We believe consumers should receive notices provided in a standardized form and manner that clearly explain in easy to understand language their choices about their coverage and any changes to that coverage. We believe this will reduce consumer confusion and help consumers make more informed decisions. Therefore, we are finalizing guidance specifying the form and manner of the Federal standard notices that issuers will use when discontinuing or renewing a product in the individual market. These notices cannot be modified in any way except where fields for customization are identified in brackets. The guidance will specify that States that are enforcing the Affordable Care Act have flexibility to develop and require their own standard notices, provided the State-developed notices are at least as protective as the Federal standard notices. We note that nothing prevents an issuer from providing additional information (such as a cover letter, summary of benefits and coverage (SBC), or other description of benefits) in the same mailing as these Federal standard notices, to the extent permitted by applicable State law.

Comment: In guidance released in June 2014, we solicited comments on whether to develop separate notices for coverage offered through the Small Business Health Options Program (SHOP) to address certain unique features of the SHOP such as employee choice. One commenter recommended the SHOP, not QHP issuers, send employers using employee choice a consolidated notice describing whether employees' current coverage will be offered again in the next benefit year, arguing that it would be difficult for employers to make coverage decisions when receiving separate renewal and discontinuation notices from multiple issuers. One commenter stated that, typically, employers in the small group market must agree before group health insurance is issued or renewed and that issuers need flexibility to modify the notices to clearly state what action must be taken.

Response: We are not specifying a final form and manner of the Federal standard notices for the small group market at this time. We recognize there are important differences in the renewal process in the small group market—particularly where an employer purchases multiple products for its employees and where employee choice is offered in the SHOP. We will continue to consider how best to structure the form and manner of the notices that must be used to inform small employers of product discontinuations and renewals, including in the SHOP, and may issue future guidance addressing the small group market. Until the issuance of further guidance, issuers may use the draft Federal standard small group notices released in the June 26, 2014 bulletin, or any forms of the notice otherwise permitted by applicable laws and regulations. We expect issuers not using the form and manner of the draft Federal standard notices released in the

June 26, 2014 bulletin to include the content described in the bulletin "Form and Manner of Notices When Discontinuing or Renewing a Product in the Group or Individual Market".

Comment: A number of commenters representing colleges and universities and health insurance issuers suggested the notices were not appropriate for students. Commenters indicated that a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students, and therefore renewal notices may be confusing to students graduating from college. They also indicated that, because the agreement is between the institution of higher education and the issuer, and the institution makes purchase decisions and, in some instances, pays premiums on behalf of students, notices should be sent to the institution of higher education rather than to students. Finally, commenters stated that providing notice 60 days prior to renewal would not provide sufficient time for institutions of higher education and issuers to finalize student health insurance plans.

Response: In response to comments, we are not requiring student health insurance issuers to provide renewal and discontinuation notices to students or to use the standardized form and manner specified by the Secretary. We will consider a student health insurance issuer to comply with the product discontinuation and renewal notice requirements if it notifies the institution of higher education regarding product discontinuations and renewals. For this purpose, student health insurance issuers may use any form and manner of the notices otherwise permitted by applicable laws and regulations. We encourage States to provide similar flexibility to issuers.

Comment: We received comments indicating that some notice content, such as references to open enrollment periods and benefit requirements (e.g., plan metal levels), is not relevant to grandfathered health plans. These comments requested flexibility for issuers to use existing forms and processes for communicating information about renewal and discontinuations of grandfathered health plans.

Response: We have updated the renewal notices to account for situations in which grandfathered plans in the individual market may come up for renewal outside of the annual open enrollment period. We note that issuers need not mention metal levels when describing benefits under a grandfathered health plan.

Comment: Some commenters representing health insurance issuers were concerned about implementing the notice requirements for non-calendar year renewals and discontinuations in 2014. These commenters recommended the standardized format be required only in connection with plan or policy years ending on or after December 31, 2014.

Response: The CMS bulletin "Form and Manner of Notices When Discontinuing or Renewing a Product in the Group or Individual Market" will provide that the form and manner of the Federal standard notice specified by the Secretary applies for discontinuation and renewals notices required to be sent for plan or policy years ending on or after December 31, 2014. For notices required to be sent prior to that time, issuers may use any form and manner otherwise permitted by applicable laws and regulations. Furthermore, as stated in the bulletin, CMS will

consider issuers that, through September 30, 2015, use either the final Federal standard notices in the bulletin, or the draft Federal standard notices in the June 26, 2014 bulletin, to have met the Secretary's specification under §146.152, §147.106 and §148.122 regarding the form and manner of the required discontinuance and renewal notices. After that time, the draft Federal standard notices in the June 26, 2014 bulletin may no longer be used to satisfy this requirement.

Comment: We received comments that generally supported the "Getting Help in Other Languages" section, which would include taglines in languages spoken by 10 percent or more of the population, indicating where persons with limited English proficiency could receive language assistance. Some commenters asked that issuers be permitted to omit this section entirely if no language met the 10-percent threshold. Some commenters recommended that issuers be allowed or encouraged to include taglines in languages that do not meet the 10-percent threshold, while one commenter emphasized that issuers notices must comply with accessibility requirements under State law, in addition to Federal law.

Response: We are finalizing the language accessibility provisions of the notices generally as they were proposed. To align with the accessibility requirements applicable to the summary of benefits and coverage (SBC) required under section 2715 of the PHS Act, we are modifying the notices to clarify that taglines will be included for languages spoken by 10 percent or more of the population in the "county." We encourage issuers, however, to include taglines in additional languages that do not meet this threshold.

Comment: Several commenters requested clarification as to which bracketed language in the notices is variable versus optional.

Response: We are releasing instructions for completing the Federal standard notices in the CMS bulletin "Form and Manner of Notices When Discontinuing or Renewing a Product in the Group or Individual Market", which delineates when fields are required or optional.

Comment: Multiple commenters representing consumer groups urged that QHP issuer notices place greater emphasis on enrollees updating their eligibility information with the Exchange to ensure they receive the most accurate advanced payments of the premium tax credit and cost-sharing reductions for the upcoming benefit year. To help enrollees more easily determine whether their income has changed, some commenters recommended the notices include enrollees' most recent income information on file with the Exchange that was used to calculate any advance payments of the premium tax credit they receive in the current benefit year.

Response: We have revised the notices in response to comments to emphasize the importance of enrollees returning to the Exchange to update their eligibility information. This will help ensure enrollees purchasing coverage through the Exchange receive the full credit they are entitled to and do not owe back amounts paid as advanced payments of the premium tax credit on their federal income tax return.

Comment: Many commenters made specific recommendations regarding the content and format of the notices with the goal of providing more consumer-friendly information. For

example, commenters suggested modifying the headline box to more clearly communicate the purpose of the notice, providing additional information to educate consumers about the open enrollment period and other important dates and deadlines, and communicating terminology relating to tax credits and coverage options in plainer language.

Response: The draft notices contained in the June 26, 2014 bulletin were tested for readability and comprehension with consumers. We are generally adopting the feedback from consumer testing.

Comment: Several commenters representing consumer groups recommended the notices provide detailed and specific information about any changes in benefits to help consumers make informed choices. Specifically, commenters recommended the notices list changes in coverage features such as premium, deductibles, cost-sharing, benefits, product network type (for example, Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO)), prescription drug formulary, and provider network. Other commenters representing health insurance issuers recommended the notices outline only the most significant changes to coverage and that issuers be permitted to enclose additional materials, such as the SBC or other benefit information, providing a more detailed description of changes.

Response: We recognize that issuers have experience communicating key coverage information to consumers. We also recognize that some States have existing requirements for disclosure of changes. While we encourage issuers to highlight in the notices significant changes made to benefits, we also permit issuers to use other documentation outside of the context of the letter that serves substantially similar purposes.