

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 146, 147, 148, 155, and 156

[CMS-9941-F]

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Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule specifies additional options for annual eligibility redeterminations and renewal and re-enrollment notice requirements for qualified health plans offered through the Exchange, beginning with annual redeterminations for coverage for benefit year 2015. This final rule provides additional flexibility for Exchanges, including the ability to propose unique approaches that meet the specific needs of their state, while streamlining the consumer experience.

DATES: These regulations are effective on **[insert a date that is 30 days from date of publication]**.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys)*, a service of the U.S. Government Printing Office. This database can be accessed via the internet at <http://www.gpo.gov/fdsys>.

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I. Background

A. Legislative Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the “Affordable Care Act.” Subtitles A and C of Title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of Title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Starting on October 1, 2013 for coverage starting as soon as January 1, 2014, qualified individuals and qualified employers have been able to purchase qualified health plans (QHPs) – private health insurance that has been certified as meeting certain standards – through competitive marketplaces called Exchanges or Health Insurance Marketplaces. The word “Exchanges” refers to both State Exchanges, also called State-based Exchanges, and Federally-facilitated Exchanges (FEEs). In this final rule, we use the terms “State Exchange” or “FEE” when we are referring to a particular type of Exchange. When we refer to “FEEs,” we are also referring to State Partnership Exchanges, which are a form of FEE.

Section 1411(f)(1)(B) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to establish procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances. Section 1321(a) of the Affordable Care Act provides authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of Title I of the Affordable Care Act. Section 2703 of the PHS Act, as added by the Affordable Care Act, and

sections 2712 and 2741 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996, require health insurance issuers in the group and individual markets to guarantee the renewability of coverage unless an exception applies.

B. Stakeholder Consultation and Input

The Department of Health and Human Services (HHS) has consulted with stakeholders on a number of policies related to the operation of Exchanges, including eligibility redetermination. HHS has held a number of listening sessions with consumers, providers, employers, health plans, and State representatives to gather public input. HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, meetings with the CMS Tribal Technical Advisory Group and an All Tribes Call on July 21, 2014 with tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all of the public input as we developed the policies in this final rule.

C. Structure of the Final Rule

The regulations in this final rule will be codified in 45 CFR parts 146, 147, 148, 155, and 156. Part 146 specifies standards related to the group health insurance market, including guaranteed renewability of coverage for employers in the group market. Part 147 specifies standards related to health insurance reforms for the group and individual health insurance markets, including guaranteed renewability of coverage. Part 148 specifies standards for the individual health insurance market, including guaranteed renewability of individual health insurance coverage. Part 155 specifies standards related to the establishment, operation, and

minimum functionality of Exchanges, including annual eligibility redeterminations. Part 156 specifies standards for health insurance issuers with respect to participation in an Exchange.

II. Provisions of the Proposed Regulations and Analysis and Responses to Comments

On July 1, 2014, we published a proposed rule in the **Federal Register** (79 FR 37262) entitled, Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges. The July 1, 2014 proposed rule (hereinafter referred to as the July 1, 2014 Annual Eligibility Redeterminations proposed rule) proposed additional options for annual eligibility redeterminations and renewal and re-enrollment notice requirements for QHPs offered through the Exchange, beginning with annual redeterminations for the 2015 benefit year. In total, we received 36 comments on the July 1, 2014 Annual Eligibility Redeterminations proposed rule. Comments represented a wide variety of stakeholders, including but not limited to states, tribal organizations, health plans, healthcare providers, consumer groups, and industry experts. We note that we received some public comments that were outside the scope of the proposed rule and are not addressed in this final rule. We have not provided explicit responses to such comments.

In this final rule, we provide a summary of each proposed provision, a summary of and responses to public comments received, and the provisions we are finalizing.

A. Part 146 – Requirements for the Group Health Insurance Market; Subpart E – Provisions Applicable to Only Health Insurance Issuers

For a discussion of the provisions of this final rule related to Part 146, see section II.B of this preamble.

B. Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

In the preamble to the July 1, 2014 Annual Eligibility Redeterminations proposed rule, we proposed establishing a notice requirement that would apply to all issuers subject to the guaranteed renewability requirements that nonrenew coverage based on continued coverage not being available in the enrollee's service area as a result of changes that do not result in product discontinuances. This proposal was intended to ensure that enrollees receive notice when the product (as defined in 45 CFR 144.103) that they purchased no longer covers their location in its service area and their coverage will be nonrenewed consistent with the guaranteed renewability provisions. We sought comment on this proposal, including the appropriate timeframe for providing the notice. We received no comments on this proposal.

In this final rule, we amend the guaranteed renewability regulations at §146.152(b)(5), §147.106(b)(5), and §148.122(c)(4) to direct an issuer that nonrenews coverage based on enrollees' movement outside the service area to provide notice in writing to each plan sponsor or individual, as applicable, (and to all participants and beneficiaries covered under the coverage) affected by such nonrenewal. This notice must be provided in the form and manner specified by the Secretary for notices of product discontinuances. This requirement applies to grandfathered and non-grandfathered coverage in the individual, small group, and large group markets offered through or outside an Exchange.

Final Rule Action: We are amending the guaranteed renewability regulations at §146.152, §147.106, and §148.122 to establish a notice requirement for issuers that nonrenew coverage based on an enrollee no longer being located within the product's service area.

C. Part 148 – Requirements for the Individual Health Insurance Market; Subpart B – Requirements Relating to Access and Renewability of Coverage

For a discussion of the provisions of this final rule related to Part 148, see section II.B of this preamble.

D. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act; Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

In §155.330, we proposed to amend paragraph (b)(4), which addresses reporting changes in the context of eligibility redeterminations during a benefit year. Our proposal provided that the Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report changes via the channels available for the submission of an application; however, we proposed that the Exchange be permitted, but not required, to allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via mail. We noted that experience has shown that eligibility changes reported by mail are often difficult to process because they frequently trigger telephone contact to gather additional information needed to process the change. We noted that, if finalized, we anticipate that the FFE would not accept changes reported via mail for the foreseeable future.

Comment: We received several comments on the proposed changes to §155.330(b)(4). Some comments requested that HHS retain the requirement that Exchanges allow enrollees to use mail to report changes during the benefit year. These commenters expressed concern that finalizing the provision as proposed would place an undue burden on vulnerable populations who may not have ready access to phones, the Internet, or transportation to in-person assisters. A few commenters recommended creating a paper change report form to elicit the correct information

to process changes reported by mail. In contrast, a few commenters supported the flexibility the proposed provision provided to Exchanges and viewed the proposal as administratively efficient.

Response: We are finalizing the provision as proposed, permitting Exchanges flexibility to determine whether to provide a process to report changes via mail and note that the FFE will be using this flexibility to not provide such a process via mail. We agree that vulnerable populations must have ready access to the Exchange to report changes. However, as noted in the preamble to the proposed rule, experience has shown that changes reported via mail often require significant follow-up and can result in delays in processing pertinent eligibility information, often to the detriment of the consumer. Accordingly, while Exchanges may allow for the reporting of changes by mail, they are not required to do so. The FFE will elect not to allow changes by mail for the foreseeable future.

Comment: One commenter asked whether the call center would be able to inform the individual the result of reporting a change. Another commenter questioned whether the Exchange would provide written confirmation, including an explanation of any action taken, to the enrollee who submits a change.

Response: In the FFE, we anticipate that the majority of enrollees will know the outcome of the changes reported through the call center during their call. As with all actions that result in a new eligibility determination, the enrollees will receive an eligibility determination notice (in the format – hard copy or electronic – that they have chosen).

Final Rule Action: We are finalizing the provision as proposed in §155.330(b)(4).

In §155.335(a), we proposed amendments to the general requirement for annual eligibility redetermination. Specifically, we proposed in paragraph (a)(1) that, except as specified in paragraphs (l) and (m) of this section, the Exchange must redetermine the eligibility

of a qualified individual on an annual basis. In paragraph (a)(2), we proposed the Exchange must conduct annual redeterminations using one of three options: (1) the procedures described in §155.335(b) through (m); (2) alternative procedures specified by the Secretary for the applicable plan year; or (3) alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process to the qualified individual or enrollee (including regarding any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

Comment: We received many comments supporting the flexibility provided by the three options for Exchanges to implement annual redetermination procedures. These commenters believed that the proposal would promote uninterrupted coverage for enrollees, as well as enhance and streamline the redetermination process.

Response: We appreciate the support for the three options we proposed for Exchanges to conduct annual eligibility redeterminations.

Comment: A few commenters supported moving Exchanges toward a single standard for annual eligibility redeterminations, primarily in accordance with §155.335(b) through (m).

Response: We anticipate that the flexibility offered to Exchanges to select procedures for conducting annual redeterminations will encourage innovation and best practices that will benefit both Exchanges and stakeholders over time. We caution that no matter which option an Exchange implements for annual redeterminations, the Exchange will be held to applicable program integrity and oversight standards to ensure an effective process.

Comment: Several commenters asked that a fully-automated redetermination process be implemented. Specifically, these commenters recommended that enrollees not be required to reapply at their Exchange in order to maintain accurate subsidies and program eligibility by the 2016 benefit year. In contrast, one commenter requested that auto-redeterminations not be implemented until 2016.

Response: We recognize the importance of a simple consumer experience during the eligibility redetermination and re-enrollment process as well as the potential benefits consumers may receive by regularly updating their application information, or simply confirming its accuracy.

Comment: We received a few comments from the issuer community citing concern that the guidance released alongside the proposed rule, specifying the alternative procedures that the FFE would use under proposed §155.225(a)(2)(ii) (the Guidance on Annual Redeterminations for 2015¹), is limited to the 2015 benefit year

Response: We indicated in the July 1, 2014 Annual Eligibility Redeterminations proposed rule that these are the procedures the FFE would use for the 2015 benefit year, if the proposed option to select these alternative procedures were finalized. The flexibility provided for the Secretary to update the alternative procedures under §155.335(a)(2)(ii) is intended to ensure that HHS can learn from the Exchanges' experience and improve the alternative procedures over time. Although HHS may issue revised alternative procedures annually, we intend to work with stakeholders to ensure there is sufficient lead time in the event changes are made.

¹ Guidance on Annual Redeterminations for Coverage for 2015, available at <http://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html>.

Comment: Commenters, particularly State-based Exchanges, were supportive of the option proposed in §155.335(a)(2)(iii) allowing Exchanges to propose alternative procedures, subject to approval by the Secretary, for conducting annual redeterminations. In contrast, one commenter encouraged HHS to standardize redetermination procedures across all Exchanges to reduce administrative burden on the issuer community.

Response: Although we understand the desire to create uniform processes across Exchanges by permitting this flexibility, Exchanges will be able to benefit from the experiences of one another and be able to apply lessons-learned to improve their consumers' redetermination experience.

Comment: We received a few comments regarding how HHS should conduct reviews of alternative procedures proposed by Exchanges. One commenter requested that reviews of alternative procedures be conducted on an individualized basis, considering state-specific factors, including operational structure, 2014 experience, and information technology capabilities. Similarly, several commenters recommended specifying additional standards that Exchanges' alternative procedures must meet as part of the review process. Other commenters recommended that alternative procedures must meet minimum federal standards, not be burdensome for consumers, and be clear improvements from the process implemented by the FFE. Finally, a commenter requested that alternative procedures for redeterminations be publicly available.

Response: We appreciate the many suggestions for standards for alternative redetermination procedures under §155.335(a)(2)(iii), as well as recommendations for the approval process for those procedures. We note that the alternative procedures we are finalizing under §155.335(a)(2)(iii) must provide consumer and program integrity protections to ensure a consistent, effective process that safeguards public funds. We will work with Exchanges to

develop and provide guidance about the process for submitting alternative procedures for approval under §155.335(a)(2)(iii).

Comment: Several commenters submitted comments regarding the substance of the Guidance on Annual Redeterminations for 2015 released contemporaneously with the July 1, 2014 Annual Eligibility Redeterminations proposed rule.

Response: The substance of the Guidance on Annual Redeterminations for 2015 is beyond the scope of the proposed rule and these comments are not addressed in this final rule.

Final Rule Action: We are finalizing §155.335(a) with a minor modification changing “plan year” to “benefit year” in §155.335(a)(2)(ii).

In §155.335(e), we proposed to revise the language regarding change reporting to generally align with the standards in §155.330(b), so that §155.335(e) would specify that, except as specified in proposed paragraph (e)(1), the Exchange must require a qualified individual to report any change with respect to the eligibility standards specified in §155.305 within 30 days of any such change. In paragraph (e)(1), we proposed that the Exchange must not require a qualified individual who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs. Finally, in paragraph (e)(2), we proposed to amend the existing provision requiring that the Exchange must allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via the channels available for submission of an application, as described in §155.405(c)(2). We proposed that this requirement would continue to apply, except that the Exchange would be permitted but not required to allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via mail.

Comment: We received some comments regarding the proposed provisions in paragraph (e). A few commenters recommended not revising the provisions in paragraph (e) at all. Other commenters sought clarification as to whether the changes reported at annual redetermination should be based on current circumstances or could be based on expected changes in the coming benefit year. Another commenter supported the proposed provision in paragraph (e)(1), which would not permit Exchanges to require a qualified individual who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs. One commenter recommended that Exchanges be required to inform people about the availability of financial assistance through the Exchange even if they are not currently receiving it. Finally, one commenter requested that Exchanges be required to include a summary of the individual's application on file in the annual redetermination notice and to ensure that this information is in plain language so it is easily accessible for all consumers.

Response: We believe the amendments made to this paragraph are necessary to generally align with the standards in §155.330, including proposed §155.330(b)(4), which governs the corresponding requirements for eligibility redeterminations during the benefit year. We note that non-income related eligibility criteria, such as residency changes must be reported within 30 days following the change in accordance with §155.330(b)(1). However, we further clarify, in response to comment, that eligibility for advance payments of the premium tax credit and cost-sharing reductions is based on projected annual household income and consumers may update that information at any time throughout the year. We also note that Exchanges may, but are not required, to remind consumers who do not currently receive advance payments of the premium tax credit or cost-sharing reductions through the Exchange that they may be eligible for this

financial assistance. Consistent with all applicable requirements, Exchanges can provide additional information at their discretion.

Comment: Several commenters requested that paragraph (e) provide a minimum threshold below which income changes would not be required to be reported for annual redetermination. We also received a comment asking that Exchanges use consistent messaging about reporting changes in income to reduce consumer confusion.

Response: We note that the provision for reporting changes during the benefit year at §155.330 does permit Exchanges to establish a reasonable threshold for reporting changes in income. However, we have declined to establish a threshold in this instance, in order to promote the greatest possible accuracy of annual eligibility redeterminations. Because all consumers will be subject to annual redeterminations, we consider the accuracy of annual redeterminations to be a priority and a significant way in which Exchanges can help reduce the risk that consumers may have to pay back any amount of their advance payments of the premium tax credit at tax filing time if, through the reconciliation process, the IRS determines the advance payment of the premium tax credit to be in excess of the premium tax credit for which the consumer was actually eligible. We note that consumers who do not have steady or predictable income have the same change reporting options as all other consumers and are able to project income-related changes for the year as part of their annual eligibility redetermination, reducing the frequency with which they must report an income-related change. Finally, Exchanges must adhere to the standards in §155.330(b) requiring consumers to report changes during the benefit year; however, Exchanges have flexibility to establish reasonable thresholds below which changes in income do not have to be reported for purposes of a mid-year redetermination. Given this

flexibility, we do not believe it is necessary to impose specific requirements regarding change reporting messages across Exchanges.

Comment: We received several comments about the requirement in proposed §155.335(e) that qualified individuals report any change with respect to eligibility standards within 30 days of such a change. One commenter questioned what the consequences were if an individual fails to report a change within 30 days or reports the change more than 30 days after the change. Another commenter suggested clarifying that individuals who report changes more than 30 days after they occur can still receive an updated eligibility determination.

Response: The requirement to report changes within 30 days is intended to ensure that eligibility determinations remain accurate in view of qualified individuals' most current eligibility information, and reduce the risk that consumers may have to repay advance payments of the premium tax credit in excess of what they are eligible for, through the reconciliation process. Individuals who report changes more than 30 days after the change will still receive an updated eligibility determination.

Comment: We received comments both supporting and opposing the proposed change in paragraph (e)(2) to eliminate the requirement for Exchanges to accept changes reported by mail, with many commenters focusing on the potential lack of access vulnerable populations may have to the methods Exchanges are required to provide for reporting changes. We also received a few general recommendations related to this provision. For example, one commenter recommended Exchanges establish tiered support through the call center. Another comment emphasized the need for a streamlined process for consumers to update their income and eligibility information without having to go through the entire application process.

Response: As noted in responses to the comments regarding the proposed changes to §155.330(b)(4), we agree that vulnerable populations must have access to the Exchange to report changes. However, changes reported by mail often require significant follow-up in order to obtain enough information to process the change, which creates a burden on both the Exchange and the consumer to complete the change reporting process. The required methods for accepting reported changes should only require a one-time interaction with the Exchange and we do not believe they inappropriately limit the ability of consumers to efficiently report changes. Therefore, we are finalizing the provision as proposed, permitting Exchanges flexibility to determine whether to accept reports of changes via mail.

Final Rule Action: We are finalizing §155.335(e) as proposed.

In §155.335(j), we proposed to modify the standards for re-enrollment in coverage. First, in paragraph (j)(1), we proposed that if an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and the product under which the QHP in which he or she was enrolled remains available for renewal, consistent with 45 CFR 147.106, such enrollee will have his or her enrollment in a QHP under the product renewed unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. In this situation, we proposed that the QHP in which the enrollee will be renewed will be selected according to the following order of priority: (1) in the same plan as the enrollee's current QHP; (2) if the enrollee's current QHP is not available, the enrollee's coverage will be renewed in a plan at the same metal level as the enrollee's current QHP; (3) if the enrollee's current QHP is not available and the enrollee's product no longer includes a plan at the same metal level as the enrollee's current QHP, the enrollee's coverage will be renewed in a plan that is one metal level higher or lower than the

enrollee's current QHP; and (4) if the enrollee's current QHP is not available and the enrollee's product no longer includes a plan that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee's coverage will be renewed in any other plan offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.

Second, in paragraph (j)(2), we proposed standards to address re-enrollment in situations in which the product under which an enrollee's QHP is offered is not available through the Exchange for renewal, consistent with §147.106. In this situation, we proposed the issuer may still re-enroll the enrollee in a different product offered by the same issuer, to the extent permitted by applicable state law, unless the enrollee terminates coverage. To the extent that an issuer is re-enrolling such an enrollee, we proposed that the plan in which the enrollee will be renewed will be selected according to the following order of priority: (1) In a plan through the Exchange at the same metal level as the enrollee's current QHP in the product offered by the issuer that is the most similar to the enrollee's current product; (2) if the issuer does not offer another plan through the Exchange at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a plan through the Exchange that is one metal level higher or lower than the enrollee's current QHP in the product offered by the issuer through the Exchange that is the most similar to the enrollee's current product; (3) if the issuer does not offer another plan through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other plan offered through the Exchange by the QHP issuer in which the enrollee is eligible to enroll; and (4) if the issuer does not offer any plan through the Exchange in which the enrollee is eligible to enroll, the enrollee may be re-enrolled in a plan offered outside the Exchange by the QHP issuer under the product

that is the most similar to the enrollee's current product, in which the enrollee is eligible to enroll. We also solicited comment regarding whether paragraphs (j)(1)(iii) and (j)(2)(ii) should only prioritize a plan with a lower metal level, and whether in general, priority should be placed on plans that have a premium that is closest to the plan in which an enrollee is currently enrolled.

Comment: One commenter noted the importance of continuity of coverage without gaps and suggested that consumers have full transparency into the process and be informed why they are being enrolled in a product and notified that some issuers who did not participate in the Exchange in the 2014 benefit year may be offering plans in the 2015 benefit year that consumers may want to consider. Similarly, a commenter did not support the re-enrollment provisions, believing they would steer members away from the shopping experience and discourage incumbent issuers from creating new and innovative products. A few commenters noted their general support for the provisions in paragraph (j) and noted that they would cause the least amount of disruption to the enrollee.

Response: We believe that the rule, as finalized, best furthers the goal of creating continuity of coverage for consumers at annual redetermination and enrollment. We agree that consumers should understand why they are being enrolled into a new plan, if applicable, and be reminded that, in all cases, after being redetermined to be eligible for coverage through the Exchange, they can return to the Exchange to shop for another plan, if they wish.

Comment: Some commenters suggested delaying the implementation of the proposed auto-enrollment policy until the 2016 benefit year due to concerns about operational readiness. A commenter asked that, if HHS did proceed with 2015 implementation, the enrollment policy be permitted only at the end of open enrollment after all enrollee outreach has been conducted.

Response: We understand that QHP issuers, Exchanges, consumers, and other stakeholders are concerned that they have time to prepare for the redetermination and enrollment period for benefit year 2015 coverage. We agree that encouraging aggressive outreach and enrollee engagement are important. However, it is important for stakeholders to have sufficient guidance to conduct redetermination and re-enrollment in accordance with federal standards during the entire open enrollment period for the 2015 benefit year. Postponing the implementation of enrollment procedures until the end of the open enrollment period could result in some consumers experiencing gaps in coverage. We believe that the Exchange should complete the redetermination and re-enrollment process early enough so that consumers have coverage (and financial assistance, if applicable) effective January 1, 2015.

Comment: A few commenters provided general comments on and alternatives to the proposed hierarchies in paragraphs (j)(1) and (2). For instance, one commenter disagreed with the use of the hierarchy because of the substantial differences in plans that a consumer may be renewed or re-enrolled into at different metal levels and in different product lines. Another commenter thought enrolling a consumer in a product or plan other than the consumer's identical QHP would cause confusion and interrupt established provider-patient care, and inflate premiums. Similarly, a few commenters requested flexibility in applying the hierarchy in cases where its application could harm consumers or where the enrollee is in a unique situation. For example, if the enrollee lives outside of the plan's service area, is enrolled in a catastrophic plan, or has aged off a parent's policy, the consumer may not have eligibility to re-enroll in the same plan.

Response: We understand the complexities that may result when consumers are placed in a different plan or product as the result of renewal or re-enrollment. However, we note that

placement into another plan or product is not intended to be the usual result of the open enrollment period. The hierarchy proposed in §155.335(j)(1) and (2) is only intended for use when a consumer's plan is no longer available or the product is discontinued, which we do not expect to be the typical scenario. The hierarchy then provides a structured process for renewal and re-enrollment which are intended to limit the differences between the consumer's current plan and new plan. We are finalizing the renewal and re-enrollment provisions with the hierarchical structure to guide the renewal and re-enrollment process while protecting the interests of the enrollee. Finally, we note that we are reviewing the unique situations noted by commenters and intend to issue guidance as to how to handle re-enrollment in these situations in the future.

Comment: We received several comments regarding the issuer's role in the re-enrollment process, particularly around the determination of when a product is "most similar" to an enrollee's current product, as stated in §155.335(j)(2)(i), (ii), and (iv). For example, a few commenters suggested that the Exchange, not the QHP issuer, should determine comparability of plans to ensure that these determinations are objective and in a consumer's best interest. Commenters requested that HHS define the criteria used in determining plan comparability and to define how a product will be determined "similar." Finally, one commenter indicated support for allowing the issuer to determine which product is most similar

Response: QHP issuers are in a unique position to understand both the characteristics of enrollees' current products and the issuers' other product offerings. As part of the QHP certification process QHP issuers in the FFE will submit crosswalks, mapping similar plans and products. Mapping enrollees in a given product to a similar product is a common industry practice.

As noted earlier, a key priority during the open enrollment period is to ensure that current enrollees have continuity of coverage and do not experience a gap in that coverage or their financial assistance. QHP issuers, coordinating with Exchanges to implement the re-enrollment and renewals, can streamline the re-enrollment and renewal process because they can easily determine whether a product will be available and, if not, what product, in accordance with the hierarchy established in this rule, would cause the least amount of disruption to the enrollee for re-enrollment.

Finally, we note that a product (as defined in §144.103) means a unique set of health insurance coverage benefits that an issuer offers using a particular product network type (for example, HMO, PPO, POS, EPO, or indemnity) within a service area. Accordingly, when mapping individuals to a new product, we expect that QHP issuers will select a product that most closely resembles the benefits, network type, and service area of the enrollee's current product. Nonetheless, we are not establishing a "most similar" standard in this final rule. States, Exchanges, and QHP issuers may use a reasonable, good faith interpretation to determine what constitutes the most similar product for this purpose. Finally, we note that State-based Exchanges that opt to implement an alternative approach to annual redeterminations, in accordance with §155.335(a)(2)(ii) or (iii), may also choose to establish a standard in this regard for renewal or re-enrollment.

Comment: A few commenters representing the issuer community submitted questions regarding the link between stand-alone dental plans and the renewal of medical coverage. For example, a commenter questioned whether there is an impact on enrollment in a stand-alone dental plan if an individual re-enrolls into a different medical plan. We received one suggestion

that re-enrollment for stand-alone dental plans should emphasize maintaining the same plan type, such as high or low coverage, and design, such as family or child-only coverage.

Response: As excepted benefits, dental plans are not subject to the guaranteed renewability standards in §147.106 and, therefore, the hierarchies in §155.335(j) do not need to apply to them in the same way.

Nonetheless, to minimize disruptions in coverage for enrollees, in the FFE, re-enrollment for stand-alone dental plan (SADP) enrollees will follow the hierarchy in §155.335(j) if the enrollee does not make any new SADP selections. We also note that SADPs are identified as either high or low plans, rather than using metal levels like medical plans. Therefore, the application of the hierarchy in the FFE for renewal or re-enrollment will account for this difference. For example, where a medical plan renewal will require, in accordance with §155.335(j)(1)(ii), renewal in a plan at the same metal level as the enrollee's current QHP for medical coverage, application of this standard to SADP will result in renewal in a plan at the same plan level, either high or low, as the enrollee's current SADP QHP. Similarly, where the hierarchy states at §155.335(j)(1)(iii) that if a plan at the same metal level as the enrollee's current plan is no longer available within the enrollee's current product, the enrollee will be renewed in a plan that is one metal level higher or lower than the enrollee's current QHP, in the SADP context, the FFE will renew or re-enroll the enrollee into the plan within the product that is offered at the permissible level other than the one of the enrollee's current SAPD (e.g., if the enrollee is currently in a high SAPD, he or she will be renewed into the low SADP).

We clarify that if an enrollee visits the FFE during the 2015 open enrollment period to change his or her QHP enrollment, he or she will need to re-select his or her SADP at the same time, because the FFE requires that QHPs and SADPs be selected at the same time. If an enrollee

doesn't return to the FFE to affirmatively select plans by December 15, 2014, the FFE will process the renewal or re-enrollment plan indicated by SADP and QHP issuers on the 2015 Plan ID Crosswalk Template in accordance with the hierarchies set forth in this rule. We note that changes in medical QHP coverage during Open Enrollment are independent of changes to SADP, and vice versa.

Comment: A few commenters requested that HHS clarify the meaning of "a plan at the same metal level" proposed at paragraph (j)(1)(ii). One commenter suggested that this meant a plan with the same QHP issuer.

Response: We clarify that the hierarchy in §155.335(j)(1) and (2) only refer to plans and products offered by the enrollee's current issuer. The hierarchy does not permit auto-enrollment into a product offered by a different issuer; however, the enrollee always has the option to shop for coverage with another issuer during the open enrollment period. We have added the word "same" before the word "issuer" in §155.335(j)(2)(i), (ii), and (iii) to help clarify the intent. We also note one technical addition to §155.335(j)(2)(ii) where we have added the word "or" at the end of the paragraph.

Comment: We received a few comments regarding the proposed requirement to re-enroll an enrollee in a plan that is one metal level higher or lower than the enrollee's current QHP at §155.335(j)(1)(iii) and (j)(2)(ii). For example, one commenter noted that the proposed rule did not specify whether the consumer or the QHP issuer decides whether to enroll into a higher or lower plan if the QHP issuer no longer offers the same level plan, and recommended that the Exchange, not the QHP issuer, make the enrollment decision. Another commenter recommended that QHP issuers must clearly inform the consumer what metal level the new plan will be and whether it is a higher or lower metal level than the consumer's existing plan.

A few commenters also addressed the request for comment regarding whether the hierarchy should only prioritize a plan with a lower metal level, or whether, in general, priority should be placed on plans that have a premium that is closest to the premium of the plan in which an enrollee is currently enrolled.

Response: We note that there was no consensus in favor of one approach over the other. As noted before, these provisions are not expected to be used frequently and are positioned in the hierarchy to promote less-disruptive re-enrollment scenarios first. These provisions are being finalized without substantive changes.

We also clarify, in response to the comments, that these provisions impose requirements on the Exchange because, although the QHP issuers will facilitate the enrollment by submitting plan crosswalks, the Exchange is ultimately responsible for ensuring that enrollment is effectuated according to the hierarchy. To reflect this, we are not finalizing proposed §155.335(j)(2)(iv), because this provision addresses enrollment outside the Exchange. In cases where an enrollee cannot be re-enrolled in a plan within the Exchange in accordance with §155.335(j)(2)(i)-(iii), the issuer will follow applicable guaranteed renewability requirements and applicable state law to complete re-enrollment outside the Exchange.

Comment: We also received comments from tribes regarding the effects of proposed renewal and re-enrollment regulations on American Indians and Alaska Natives (AI/ANs), noting that the zero and limited cost-sharing plan variations available to AI/ANs cross the four metal levels. The commenters recommended that the regulations be revised to give QHP issuers the flexibility to keep AI/ANs in their current plan or another bronze level plan. Finally, the commenters highlighted the importance of addressing this special circumstance for AI/ANs because they should always have an alternate zero or limited cost-sharing plan at any level

available to them and should never be moved to a higher level plan if their zero or limited cost-sharing plan variation is eliminated.

Response: All QHPs must offer zero and limited cost-sharing plan variations at every metal level and, thus, if a particular QHP is no longer offered, the AI/AN should be able to enroll in another zero or limited cost-sharing plan variation at the same metal level, if a QHP is offered at that metal level. However, if a QHP is not available at a specific metal level, such as the bronze metal level, then no plan variations will be available at that level. If a qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act is auto-enrolled in a higher level metal plan than desired, pursuant to §155.420(d)(8), he or she can change his or her enrollment once per month, mitigating any undesired outcome of automatic enrollment.

Comment: One commenter urged HHS to adopt a mechanism to accommodate auto-enrollment within an insurance holding company system.

Response: We disagree that a QHP issuer should be permitted to auto-enroll individuals into a product of another licensed issuer. Section 2703(c) of the Public Health Service (PHS) Act and §147.106(c) provide that, in any case in which a QHP issuer decides to discontinue offering a particular product offered in the individual market, that product may be discontinued by the issuer in accordance with applicable state law in the applicable market only if certain requirements are met. Among the requirements for product discontinuation is that the issuer must offer to each individual provided that particular product the option to purchase, on a guaranteed availability basis, any other health insurance coverage offered by the issuer in that market. An issuer does not satisfy the requirement to offer other health insurance coverage currently being offered “by the issuer” if it auto-enrolls qualified individuals into a product of

another issuer that is separately licensed to engage in the business of insurance in a State. Nothing in the PHS Act or the regulations under the PHS Act prevents an issuer that elects to discontinue offering all health insurance coverage in a market (market withdrawal under §147.106(d)) from auto-enrolling affected individuals into a product of another licensed issuer, to the extent permitted by applicable state law.

Comment: We received many comments concerning the possibility for enrollees to be re-enrolled in a plan that prevents them from continuing to receive financial assistance through the Exchange. Two specific scenarios created concern for commenters. First, commenters were concerned that enrollees might lose access to cost-sharing reductions if they are re-enrolled into a non-silver level plan. Second, commenters noted that enrollees who are re-enrolled into a product outside the Exchange would lose eligibility for both advance payments of the premium tax credit and cost-sharing reductions. We received many recommendations regarding how to address these two scenarios. Several commenters urged HHS to simply prevent issuers from auto-enrolling qualified individuals into plans outside the Exchange if the qualified individual is eligible for advance payments of the premium tax credit, or into a non-silver level plan if the qualified individual is eligible for cost-sharing reductions. Similarly, a few commenters suggested that we add consideration of a plan's cost-sharing structure as a factor in any auto-enrollment schema. Another commenter suggested that if an individual is re-enrolled in a plan that results in a negative impact on his or her financial assistance that the Exchange should permit the individual to change plans during open enrollment and for a 90-day period following open enrollment.

Response: We agree with commenters that losing access to advance payments of the premium tax credit and/or cost-sharing reductions in order to maintain coverage under a product

that is no longer available through an Exchange is not the preferable outcome for renewal and re-enrollment. The hierarchy of renewal and re-enrollment options set out in §155.335(j) was created in order to minimize such disruptions. We contend that instances where an enrollee will be re-enrolled into coverage that prevents the enrollee from taking advantage of advance payments of the premium tax credit and/or cost-sharing reductions will be rare. We note that §156.200(c)(1) requires all issuers offering a QHP through the Exchange to offer at least one plan at the silver level. Issuers generally have found that plans offered at this level are their most popular plans, and they understand the role of advance payments of the premium tax credit and/or cost-sharing reductions in making coverage affordable to their enrollees. We also note that the hierarchy is designed to prioritize options that generally do not eliminate eligibility for advance payments of the premium tax credit (or the premium tax credit) and/or cost-sharing reductions.

Section 155.335(j)(2) of this final rule specifically addresses re-enrollment in Exchange coverage when an enrollee's current product is not available for renewal "through the Exchange." Nonetheless, the product may continue to be available for renewal outside the Exchange. We interpret the guaranteed renewability provisions of §147.106 to mean that, if the product remains available for renewal, including outside the Exchange, the issuer must renew the coverage within the product in which the enrollee is currently enrolled at the option of the enrollee, unless an exception to the guaranteed renewability requirements applies. However, for the reasons stated above, to the extent that the issuer is subject to 45 CFR 155.335(j) with regard to an enrollee's coverage through the Exchange, the issuer must, subject to applicable state law regarding automatic enrollments, automatically enroll the enrollee in accordance with the re-enrollment hierarchy, even where that results in re-enrollment in a plan under a different product

offered by the same QHP issuer through the Exchange. Enrollments completed pursuant to §155.335(j) will be considered to be a renewal of the enrollee's coverage, provided the enrollee also is given the option to renew coverage within his or her current product outside the Exchange. We intend to evaluate this policy and may provide future guidance on how an issuer continuing to offer an enrollee's product outside the Exchange can comply with the guaranteed renewability provisions. We reiterate that enrollees have the opportunity to shop for a new plan during the open enrollment period regardless of whether they are automatically re-enrolled into plan that does not meet their needs. We encourage Exchanges and QHP issuers to remind enrollees of that option.

Final Rule Action: We are finalizing §155.335(j) with a few modifications. First, we have added the word "same" before the word "issuer" in §155.335(j)(2)(i), (ii), and (iii). Second, we have added the word "or" at the end of §155.335(j)(2)(ii). We are not finalizing §155.335(j)(2)(iv).

B. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges; Subpart M – Qualified Health Plan Issuer Responsibilities

In 45 CFR 147.106(f)(1) of the final rule entitled, "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," published on May 27, 2014 (79 FR 30240) (Market Standards Rule), we specified that health insurance issuers of non-grandfathered plans in the individual market will provide written notice of renewals before the first day of the next annual open enrollment period in a form and manner specified by the Secretary. Under §147.106(c)(1), health insurance issuers of non-grandfathered plans in the individual market also will provide written notices of product discontinuances.

We proposed adding a new §156.1255, which would require a health insurance issuer in the individual market that is renewing an enrollment group's coverage in a QHP offered through the Exchange (including a renewal with modifications), or that is discontinuing a product that includes plans offered through the Exchange and automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange, to include certain information in the renewal or discontinuation notices, as applicable. We proposed that the additional information include premium and advance payment of premium tax credit information, an explanation of the requirement to report changes to the Exchange, a description of the reconciliation process for advance payments of the premium tax credit, and an explanation that if the enrollment group's coverage is being renewed in a QHP at a different (non-silver) metal level, cost-sharing reductions will not be provided for the upcoming year unless the enrollment group changes its enrollment to select a new silver-level plan.

Finally, we proposed establishing a notice requirement that would apply to all plans subject to the guaranteed renewability requirements that nonrenew coverage based on continued coverage not being available in the enrollee's service area as a result of changes that do not result in product discontinuances. We sought comment on this proposal, including the appropriate timeframe for providing the notice.

Comment: Commenters were generally supportive of the additional required content proposed for the renewal and re-enrollment notices. For example, commenters approved of the inclusion of information about changes to the advance payment of the premium tax credit and the reminders of the requirement to report changes, the reconciliation process, and the availability of cost-sharing reductions. Two commenters were concerned that the issuer notice content would not encourage enrollees to take any action. A few commenters urged issuers to ensure notices

are provided in plain language and include appropriate accessibility features. Finally, one commenter recommended including language reminding enrollees to consider how changes in their enrollment might affect their access to financial assistance for health coverage and that they have the option to shop for other coverage.

Response: We appreciate the support received for the proposed additional required content for the renewal and re-enrollment notices. We note that, pursuant to §156.250, issuer notices must comply with the standards for notices found at §155.230(b) (which also cross-references §155.205(c)), which includes accessibility and readability requirements.

We also note that issuers are required to provide enrollees a Summary of Benefits and Coverage (SBC), a document that summarizes benefits and cost-sharing under a plan. Issuers must provide the SBC at various specific points in time, including annually upon renewal. At renewal, the SBC must reflect any modified policy or plan terms that will be effective on the first day of the new policy or benefit year. If a written application is required for renewal or reissuance, the SBC must be provided no later than the date written application materials are distributed. If renewal or reissuance is automatic, the SBC generally must be provided no later than 30 days prior to the first day of the new policy or benefit year. 45 CFR 147.200(a)(1)(ii)(E)(2) and (a)(1)(iv)(C)(2). This requirement also applies in the situation in which an issuer nonrenews or discontinues coverage under an existing health insurance product and, consistent with applicable Federal and State law, automatically enrolls an individual or plan sponsor (and participants and beneficiaries covered under such coverage) in a plan under a different product offered by such issuer in which the individuals are eligible to enroll. As such, the requirements to provide an SBC in connection with an automatic renewal or reissuance of coverage apply and the SBC generally is required to be provided no later than 30 days prior to

the first day of the new policy or benefit year. An issuer is not prohibited from providing the SBC earlier than 30 days prior to the new policy or benefit year, and when possible issuers are encouraged to provide SBCs by the first day of the open enrollment period to allow individuals enough time to consider their coverage options available with respect to the upcoming policy or benefit year. If an issuer does provide the SBC earlier than 30 days prior to the new plan or policy year, and there are no changes to the information reflected in the SBC prior to the first day of the new plan or policy year, the issuer will have satisfied the requirement to provide the renewal SBC.

Comment: Some commenters were concerned that the implementation of §156.1255(a), which requires the inclusion of premium and advance payments of the premium tax credit information, would not provide useful information to the enrollee. Specifically, commenters noted that the advance payments of the premium tax credit information could reflect the enrollee's 2014 advance payment of the premium tax credit while the premium information could reflect 2015 benefit year costs. The commenters also suggested that if updated information regarding the household size and income was not available, the Exchange should either perform outreach encouraging the enrollee to obtain an updated eligibility determination or the Exchange should provide advance payment of the premium tax credit information reflecting the second lowest-cost silver plan for that Exchange and enrollee-type.

Response: We agree that it is important to provide enrollees with information that will help them make informed decisions about their coverage for the upcoming benefit year. As part of that process, and as discussed in the guidance issued alongside the July 1, 2014 Annual Eligibility Redeterminations proposed rule, the FFE will encourage enrollees to return to the Exchange to update their application information and obtain an eligibility determination that will

account for updated FPL thresholds, household size, and income, as all Exchanges must require enrollees to report changes with respect to eligibility standards.

In the proposed rule, §156.1255(a) would have required QHP issuers to provide the premium and premium tax credit information for the enrollee's 2015 plan. In the final rule, we retain this requirement but clarify that issuers must provide advance payment of the premium tax credit information by adding the phrase "advance payment of the" before "premium tax credit information[.]"

Comment: We received comments regarding providing specific notice messages for re-enrollment options for American Indians and Alaskan Natives (AI/ANs). For example, cost-sharing reductions for these enrollees is implemented differently from how it is implemented for other enrollees, and the information described in §156.1255(d) may not be applicable for these enrollees, who may need a more targeted explanation.

Response: We understand the concern that AI/ANs receive the appropriate messaging regarding requirements specific to their coverage. We have revised §156.1255(d) by adding a clarification that in accordance with §155.305(g)(1)(ii), cost-sharing reductions are only available to an individual who is not an Indian if he or she is enrolled in a silver-level QHP. This reflects that AI/ANs can continue to enroll or renew in a zero or limited cost-sharing plan at any metal level and still qualify for cost-sharing reductions. The FFE will continue to provide education and outreach to AI/ANs regarding the cost-sharing reductions that may be available to them at any metal level. We also are making a technical edit to remove the word "with" from §156.1255(d) and replace it with "being provided[.]"

Final Rule Action: We are finalizing the provisions proposed in §156.1255 with minor modifications. We are replacing the phrase "discontinuing a product" with "nonrenewing

coverage” to clarify that the additional notice content required by §156.1255 will be included in notices required to be provided not only when issuers discontinue a product, but also when issuers nonrenew coverage based on enrollees’ movement outside the service area, as set forth in §147.106(b)(5) of this final rule and discussed in more detail in section II.B of this preamble.

We are also adding a cross-reference to §147.106(b)(5), accordingly. We are adding the phrase “advance payment of the” before “premium tax credit information” in §156.1255(a). We clarified the reference to §155.305(g)(1)(ii) by adding “of this subchapter” after the citation. Finally, we are removing the word “with” from §156.1255(d) and replacing it with “being provided[.]”

III. Collection of Information Requirements

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA), we have also submitted to the Office of Management and Budget (OMB) the final information collection request for emergency approval review for a 180-day period. While the collection is necessary to ensure compliance with an initiative of the Administration, we are requesting emergency review under 5 CFR 1320.13(a)(2)(i) because public harm is reasonably likely to result if the regular clearance procedures are followed.

In the July 1, 2014 Annual Eligibility Redeterminations proposed rule (79 FR 37262), we solicited public comments on each of the sections identified as containing information collection requirements (ICRs), as required by section 3506(c)(2)(A) of the PRA. We received several comments on the notice requirements, which have been addressed earlier in the preamble. We

generally used data from the Bureau of Labor Statistics to derive average labor costs (including fringe benefits) for estimating the burden associated with the ICRs.

The approval of this data collection process is essential to ensuring that renewal and discontinuance notices associated with the 2015 benefit year are provided to consumers in a timely manner prior to the open enrollment period for the 2015 benefit year. Consumers will need the information in these notices in order to make decisions regarding their coverage for the 2015 benefit year.

ICRs Regarding Renewal and Re-enrollment Notice Requirements (§156.1255)

As specified in §156.1255, a health insurance issuer that is renewing an enrollment group's coverage in the individual market in a QHP offered through the Exchange (including a renewal with modifications), in accordance with §147.106, or that is discontinuing a product and automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange, in accordance with §155.335, must include certain information in the written notice required by §147.106(b)(5), (c)(1), or (f)(1), as applicable.

Contemporaneously with the issuance of this final rule, we are issuing a bulletin specifying the form and manner of the notices by providing standard notices that issuers generally will use when discontinuing or renewing coverage in the individual market.

Since there are existing requirements for issuers to send renewal and discontinuance notices, we only estimate the burden for QHP issuers to revise current notices to comply with the provisions of this final rule. We estimate that there are 575 QHP issuers and assume that they would all revise their existing notices to comply with the requirements in this final rule.

For renewal notices, we estimate that, for each issuer, it will require three hours of clerical labor (at a cost of \$33.67 per hour) to prepare the notice and one hour for a senior

manager (at a cost of \$75.34 per hour) to review it. We also estimate that it will take a computer programmer 20 hours (at a cost of \$52.53 per hour) to write and test a program to automate the notices. The total burden for each issuer to prepare the notice will be 24 hours with an equivalent cost of approximately \$1,277. For all 575 QHP issuers, the total burden will be 13,800 hours with an equivalent cost of approximately \$705,479.

For re-enrollment (or nonrenewal) notices, we estimate that, for each issuer, it will require two hours of clerical labor (at a cost of \$33.67 per hour) to prepare the notice and one hour for a senior manager (at a cost of \$75.34 per hour) to review the notice. We also estimate that it will take a computer programmer six hours (at a cost of \$52.53 per hour) to write and test a program to automate the notices. The total annual burden for each issuer to prepare the notice will be nine hours with an equivalent cost of approximately \$492. For all 575 QHP issuers, the total annual burden will be 5,175 hours with an equivalent cost of approximately \$263,265. These burden estimates are lower than those in the proposed rule, because we assume that simplifications made to the form of the nonrenewal notices to reduce variable text will reduce clerical and computer programming hours by approximately one third.

The accompanying bulletin “Form and Manner of Notices When Discontinuing or Renewing a Product in the Group or Individual Market” provides that states that are enforcing the Affordable Care Act may develop their own standard notices, provided the State-developed notices are at least as protective as the Federal standard notices. However, we anticipate that fewer than 10 states would opt for this alternative. Under 5 CFR 1320.3(c)(4), this requirement is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

We have submitted an information collection request to OMB for review and approval of the ICRs contained in this final rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

IV. Regulatory Impact Statement

A. Summary

We are publishing this final rule to implement the protections intended by the Congress in the most economically efficient manner possible. We have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

B. Executive Orders 12866 and 13563

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule -- (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal

governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (for example, \$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the OMB. We have concluded that this final rule is not likely to have economic impacts of \$100 million or more in any one year, and therefore does not meet the definition of “economically significant rule” under Executive Order 12866.

1. Need for Regulatory Action

This final rule specifies additional options for annual eligibility redeterminations, and renewal and re-enrollment notice requirements for QHPs in the Exchange beginning with annual redeterminations for coverage for benefit year 2015.

2. Summary of Impacts

We do not expect that there will be additional costs related to the additional options provided in this final rule for annual eligibility redeterminations, because we believe Exchanges will implement an alternative method only if doing so is less costly than the current method.

QHP issuers will incur costs to prepare and send renewal notices to comply with the final provisions, as detailed in section III of this final rule. States that choose to develop their own notices will incur costs to do so. Providing consumers with information such as benefit changes and premium amounts will enable them to make decisions regarding their coverage for the next benefit year.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a regulation to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a "small entity" as: (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a nonprofit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000 (states and individuals are not included in the definition of "small entity"). HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. We do not believe that this threshold will be reached by the provisions of this final rule.

D. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule that includes a federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold level is approximately \$141 million.

UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of cost, mainly those "Federal mandate" costs resulting from: (1) Imposing enforceable duties on State, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

This final rule will allow Exchanges to choose one of three methods for conducting annual eligibility redeterminations. We assume that Exchanges will choose an alternative

method only if it is less costly than the current method. It will also require QHP issuers to include specific information in renewal and nonrenewal notices sent to enrollees and issuers will incur costs to comply with this requirement. States that choose to develop their own notices will incur costs to do so. Consistent with policy embodied in UMRA, this final rule has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

E. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

States are the primary regulators of health insurance coverage, and State laws will continue to apply to health insurance coverage and the business of insurance. However, if any State law or requirement prevents the application of a Federal standard, then that particular State law or requirement will be preempted. State requirements that are more stringent than the Federal requirements will not be preempted by this final rule. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more restrictive than the Federal law.

F. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, et seq.), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule

along with other specified information. This final rule will be transmitted to Congress and the Comptroller General in accordance with such provisions.

List of Subjects45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

45 CFR Part 148

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administration and calculation of advance payments of the premium tax credit, Administrative practice and procedure, Advance payments of premium tax credit, Cost-sharing reductions, Health care access, Health insurance, Reporting and recordkeeping requirements, State and local governments.

45 CFR Part 156

Administrative practice and procedure, Health care, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 146, 147, 148, 155, and 156 as set forth below:

PART 146 – REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

2. Section 146.152 is amended by revising paragraph (b)(5) to read as follows:

§ 146.152 Guaranteed renewability of coverage for employers in the group market.

* * * * *

(b) * * *

(5) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §146.150(c); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

* * * * *

PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

3. The authority citation for part 147 continues to read as follows:

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

4. Section 147.106 is amended by revising paragraph (b)(5) to read as follows:

§ 147.106 Guaranteed renewability of coverage.

* * * * *

(b) * * *

(5) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §147.104(c)(1)(i); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

* * * * *

PART 148 – REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

5. The authority citation for part 148 continues to reads as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

6. Section 148.122 is amended by revising paragraph (c)(4) to read as follows:

§ 148.122 Guaranteed renewability of individual health insurance coverage.

* * * * *

(c) * * *

(4) Movement outside the service area. For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-

related factor of covered individuals; provided the issuer provides notice in accordance with the requirements of paragraph (d)(1) of this section.

* * * * *

PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

7. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083).

8. Section 155.330 is amended by revising paragraph (b)(4) to read as follows:

§155.330 Eligibility redetermination during a benefit year.

* * * * *

(b) * * *

(4) The Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in §155.405(c)(2), except that the Exchange is permitted but not required to allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via mail.

* * * * *

9. Section 155.335 is amended by revising paragraphs (a), (e), and (j) to read as follows:

§155.335 Annual eligibility redetermination.

(a) General requirement. (1) Except as specified in paragraphs (l) and (m) of this section, the Exchange must redetermine the eligibility of a qualified individual on an annual basis.

(2) The Exchange must conduct annual redeterminations required under paragraph (a)(1) of this section using one of the following:

- (i) The procedures described in paragraphs (b) through (m) of this section;
- (ii) Alternative procedures specified by the Secretary for the applicable benefit year; or
- (iii) Alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process to the qualified individual or enrollee (including regarding any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

* * * * *

(e) Changes reported by qualified individuals. Except as specified in paragraph (e)(1) of this section, the Exchange must require a qualified individual to report any change with respect to the eligibility standards specified in §155.305 within 30 days of such change.

(1) The Exchange must not require a qualified individual who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs.

(2) The Exchange must allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application, as described in §155.405(c)(2), except that the Exchange is permitted but not

required to allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via mail.

* * * * *

(j) Re-enrollment. If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination—

(1) And the product under which the QHP in which he or she is enrolled remains available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee will have his or her enrollment through the Exchange in a QHP under that product renewed, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(1) occurs under the same product in which the enrollee was enrolled, as follows:

(i) The enrollee's coverage will be renewed in the same plan as the enrollee's current QHP, unless the current QHP is not available.

(ii) If the enrollee's current QHP is not available, the enrollee's coverage will be renewed in a plan at the same metal level as the enrollee's current QHP.

(iii) If the enrollee's current QHP is not available and the enrollee's product no longer includes a plan at the same metal level as the enrollee's current QHP, the enrollee's coverage will be renewed in a plan that is one metal level higher or lower than the enrollee's current QHP;
or

(iv) If the enrollee's current QHP is not available and the enrollee's product no longer includes a plan that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee's coverage will be renewed in any other plan offered under

the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.

(2) And the product under which the QHP in which he or she is enrolled is not available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee may be enrolled in a plan under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(2) occurs as follows:

(i) The enrollee will be re-enrolled in a plan through the Exchange at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product;

(ii) If the issuer does not offer another plan through the Exchange at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a plan through the Exchange that is one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(iii) If the issuer does not offer another plan through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other plan offered through the Exchange by the same issuer in which the enrollee is eligible to enroll.

* * * * *

**PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE
AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

10. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

11. Add §156.1255 to read as follows:

§156.1255 Renewal and re-enrollment notices.

A health insurance issuer that is renewing an enrollment group’s coverage in an individual market QHP offered through the Exchange (including a renewal with modifications) in accordance with §147.106 of this subchapter, or that is nonrenewing coverage offered through the Exchange and automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange in accordance with §155.335 of this subchapter, must include the following information in the applicable notice described in §147.106(b)(5), (c)(1), or (f)(1) of this subchapter:

(a) Premium and advance payment of the premium tax credit information sufficient to notify the enrollment group of its expected monthly premium payment under the renewed coverage, in a form and manner specified by the Exchange, provided that if the Exchange does not provide this information to enrollees and does not require issuers to provide this information to enrollees, consistent with this section, such information must be provided in a form and manner specified by HHS;

(b) An explanation of the requirement to report changes to the Exchange, as specified in §155.335(e) of this subchapter, the timeframe and channels through which changes can be reported, and the implications of not reporting changes;

(c) For an enrollment group that includes an enrollee on whose behalf advance payments of the premium tax credit are being provided, an explanation of the reconciliation process for advance payments of the premium tax credit established in accordance with 26 CFR 1.36B-4; and

(d) For an enrollment group that includes an enrollee being provided cost-sharing reductions, but for whom no QHP under the product remains available for renewal at the silver level, an explanation that in accordance with §155.305(g)(1)(ii) of this subchapter, cost-sharing reductions are only available to an individual who is not an Indian if he or she is enrolled in a silver-level QHP.

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Dated: August 15, 2014

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: August 27, 2014

Sylvia M. Burwell,

Secretary.

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