DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 156

[CMS-9941-P]

RIN 0938-AS32

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: Proposed rule.

SUMMARY: This proposed rule would specify 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 plan year 2015. In particular, this proposed rule would provide additional flexibility for Marketplaces, including the ability for Marketplaces to propose unique approaches that meet the specific needs of their State, while streamlining the consumer experience.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 28, 2014.

ADDRESSES: In commenting, please refer to file code CMS-9941-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9941-P,

P.O. Box 8010,

Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9941-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, S.W.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Benjamin Walker, (301) 492-4430.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or

confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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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 proposed 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 (FFEs). In this proposed rule, we use the terms "State Exchange" or "FFE" when we are referring to a particular type of Exchange. When we refer to "FFEs," we are also referring to State Partnership Exchanges, which are a form of FFE.

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. Under section 2703 of the PHS Act, as added by the Affordable Care Act, health insurance issuers in the group and individual markets must guarantee the renewability of coverage unless an exception applies.

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on a number of polices 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, and meetings 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 proposed rule.

C. Structure of the Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 155 and 156. Part 155 specifies standards relative 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

A. 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

Section 1411(f)(1)(B) of the Affordable Care Act directs 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.

On March 27, 2012, we published a final rule entitled Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310). The final rule added 45 CFR 155.335, which, together with the provisions in 45 CFR 155.330 on eligibility redeterminations during a benefit year, implements section 1411(f)(1)(B) of the Affordable Care Act. On July 15, 2013, we amended §155.335 in a final rule entitled Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (78 FR 42160, 42319).

Under the process currently defined in §155.335, the Exchange will provide a notice to all individuals who have been determined eligible for enrollment in a QHP through the Exchange (qualified individuals) in advance of the annual open enrollment period, consistent with §155.335(c). For 2015, current regulations in §155.335(d)(1) specify that this notice and the annual open enrollment period notice described in §155.410(d) be provided as a single, coordinated notice. For an individual who requested an eligibility determination for insurance affordability programs and who authorized the Exchange to obtain the most recent tax return

information available from the Secretary of the Treasury for the purposes of annual redetermination, this notice will include a projected eligibility determination for insurance affordability programs for the following year that is computed based on the updated income and family size information, all other eligibility information currently on file with the Exchange, and plan premiums for the following year. Specifically, if advance payments of the premium tax credit (APTC) are being paid on such an enrollee's behalf and the tax filer authorized the Exchange to obtain updated tax data for the purposes of annual redetermination, the Exchange will recalculate advance payments of the premium tax credit and cost-sharing reductions (CSR) for the upcoming year in accordance with updated income and family size information and premium data for the applicable benchmark plan, as defined in 26 CFR 1.36B-3(f), calculated using premiums for the upcoming year. Consistent with §155.335(e), the Exchange will require qualified individuals to report changes. The process currently established in regulation allows an individual who is enrolled in a QHP through the Exchange and whose QHP remains available to renew coverage for the following year without reapplying or having to take other actions. This is a key element of the redetermination process, since it enables a streamlined renewal process for enrollees and also reduces administrative costs for States and the Federal government.

Based on the authority in sections 1411(f)(1)(B) and 1321(a) of the Affordable Care Act, we propose to modify §155.335(a) to allow for an Exchange to choose one of three methods for conducting annual redeterminations. To accommodate proposed new paragraph (a)(2), we propose to renumber existing paragraph (a) as paragraph (a)(1). Then, in proposed paragraph (a)(2), we propose that the Exchange must conduct annual redeterminations using one of the sets of procedures described in proposed paragraphs (a)(2)(i), (a)(2)(ii), or (a)(2)(iii). First, in proposed paragraph (a)(2)(i), we propose that the Exchange may utilize the existing procedures

described in §155.335(b) through (m). Second, in paragraph (a)(2)(ii), we propose that the Exchange may utilize alternative procedures specified by the Secretary for the applicable plan year. We note that, contemporaneously with this proposed rule, the Secretary is providing guidance describing alternative procedures that would be available to Exchanges under paragraph (a)(2)(ii) for annual redeterminations for coverage for plan year 2015 if this proposal is finalized. We are providing this guidance at the same time as this proposed rule given the limited amount of time available for Exchanges and issuers to develop and test the systems and processes that will be needed to implement the annual redetermination process. If this proposal is finalized, Federally-facilitated Exchanges will adopt the alternative procedures specified in this guidance for plan year 2015. Also, if this proposal is finalized, we expect that updated guidance under paragraph (a)(2)(ii) may be provided on an annual basis. Third, in proposed paragraph (a)(2)(iii), we propose that the Exchange may utilize 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 any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections. We note that paragraph (a)(2)(iii) is designed to enable Exchanges to propose annual redetermination procedures that would deliver on the key goals of the annual redetermination process, including those specified in this paragraph. We solicit comment regarding standards for approving alternative procedures, and on other elements of the annual redetermination process, as well as how it affects renewal for individuals who are enrolled in a QHP through the Exchange. We also note that special procedures may be needed for an Exchange that is transitioning the eligibility and enrollment

functions from Federal to State operation, or vice versa. We will work closely with affected States to facilitate these transitions.

In addition to the proposal to allow Exchanges to choose one of three options for performing annual redeterminations, we propose to make three amendments to the detailed procedures described in §155.335 and one corresponding amendment to §155.330, which governs eligibility redetermination during a benefit year. First, in §155.335(e), we propose 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), 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. Under proposed paragraph (e)(1), the Exchange would not be permitted 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. Unlike §155.330, we do not propose to allow the Exchange to establish a reasonable threshold for changes in income, such that a qualified individual who experiences a change in income that is below the threshold would not be required to report such change, since we believe that reporting of all income changes is important at the time of annual redetermination. With this exception, the proposed standards are identical to those currently established in 45 CFR §155.330(b). We propose these changes to paragraph (e) because the existing text refers to reporting changes with respect to the information included in the annual redetermination notice, which is not required to include a summary of the qualified individual's application information on file, although an Exchange may opt to include this information. These proposed changes would align reporting requirements with the notice

and ensure that Exchanges require relevant changes to be reported in a timely manner, consistently throughout the year.

Second, in proposed §155.335(e)(2), we propose to amend the existing provision which specifies 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 propose that this requirement would continue to apply, except that the Exchange would no longer be required to allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via mail. We also propose the same change to §155.330(b)(4), which addresses the reporting of changes in the context of eligibility redetermination during a benefit year. Accepting changes via mail would frequently require follow-up telephone contact with individuals attempting to report changes in order to obtain answers to questions that may be triggered by the reported changes. We propose this because of the dynamic nature of the eligibility process, under which, for example, the Exchange should only ask questions about an individual's access to qualifying coverage in an eligible employer-sponsored plan for an individual who has a level of income for his or her family size that would qualify him or her for advance payments of the premium tax credit or cost-sharing reductions, if he or she is otherwise eligible. With a paper process, under this example, it frequently would not be possible to know in advance whether information about an individual's access to qualifying coverage in an eligible employer-sponsored plan would need to be collected based on a reported change in income or family size. Since change reporting via mail would frequently trigger subsequent telephone contact, we believe it would promote administrative efficiency to eliminate the requirement to accept change reporting via mail while encouraging use of the telephone option, during which a call center representative can use the

dynamic application to ask the qualified individual any follow-up questions that may arise from the change report. We note that our proposed policy would continue to require that an Exchange must permit change reporting online, via telephone, and in person with the assistance of Navigators, certified application counselors, and other in-person assistance personnel, and that an Exchange could choose to permit change reporting via mail. If this proposal is finalized, we anticipate that the Federally-facilitated Exchange would not accept changes reported via mail for the foreseeable future. We also note that this rule does not propose to modify 42 CFR 435.916(a)(3)(B) or (c), which specify that a Medicaid agency must allow an individual to respond to an annual redetermination or report changes via mail.

Third, we propose to modify the standards for re-enrollment in coverage in paragraph (j). First, in paragraph (j)(1), we propose 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 propose that the QHP in which the enrollee will be renewed will be selected according to the following order of priority: first, in the same plan as the enrollee's current QHP, unless the current QHP is not available; second, 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; third, 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 fourth, 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.

In paragraph (j)(2), we propose 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 45 CFR 147.106. In this situation, the QHP issuer may still re-enroll the enrollee in a different product offered by the same QHP 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 propose that the plan in which the enrollee will be renewed will be selected according to the following order of priority: first, 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; second, 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; third, 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 fourth, 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 note

that the Exchange would not send an enrollment transaction for an enrollment outside the Exchange, and that premium tax credits and cost-sharing reductions are not available for enrollment that is not through the Exchange.

The proposed changes to this provision include minor changes to improve clarity, amendments to reflect that renewal of coverage in a QHP through the Exchange intersects with §147.106, which provides market-wide standards for guaranteed renewability of coverage offered both through and outside the Exchange, and a specific order of priority to ensure that renewal of and re-enrollment in coverage in a plan through the Exchange occurs through the Exchange, and is in products that are as similar to the enrollee's existing product as possible, in order to minimize disruption, enable consumers to continue with advance payments of the premium tax credit and cost-sharing reductions (which are only available for enrollment through the Exchange) and limit consumer confusion. Further, the current text of paragraph (j), if read separately from §147.106, could give the incorrect impression that a QHP enrollee would have his or her coverage in a QHP renewed even if the product under which the QHP was offered was no longer available for renewal, consistent with §147.106. Accordingly, the proposed language is designed to clarify the dependency of renewal of coverage in a QHP through the Exchange on the continuing availability of the product under which the QHP is offered in accordance with market-wide standards. We solicit comments on these proposed standards and on the proposed order in which plans would be selected for renewal of and re-enrollment in coverage. In particular, we solicit 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.

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 45 CFR 147.106(c)(1), health insurance issuers of non-grandfathered plans in the individual market also will provide written notices of product discontinuances.

We propose adding to subpart M 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 qualified health plan 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 propose that the additional information include the following: (1) premium and 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; (2) an explanation of the requirement to report changes to the Exchange, the timeframe and channels through which changes can be reported, and the implications of not reporting changes; (3) for an

enrollment group that includes an enrollee on whose behalf advance payments of the premium tax credit are being provided, a description of the reconciliation process for advance payments of the premium tax credit; and (4) for an enrollment group that includes an enrollee whose coverage includes cost-sharing reductions, if the enrollment group's coverage is being renewed in a QHP at a different (non-silver) metal level, an explanation that, unless the enrollment group changes its enrollment to select a new silver-level plan, cost-sharing reductions will not be provided for the upcoming year. In accordance with §147.106(f)(1), renewal notices would need to be provided no later than the first day of the open enrollment period for the upcoming plan year. An issuer also may provide this notice along with the applicable summary of benefits and coverage notice that is provided at renewal in accordance with 45 CFR 147.200. We seek comment on this proposal.

Contemporaneously with the issuance of this proposed rule, we are specifying the form and manner of the notices described in 45 CFR 146.152, 147.106, and 148.122 by providing standard notices for issuers to use when discontinuing or renewing coverage. These notices take into account the feedback we received on the draft notices issued contemporaneously with the proposed Market Standards Rule.[1] We believe that adding the information that would be specified pursuant to §156.1255 to the renewal notices required under §147.106 would best assure that qualified individuals receive, in a single notice, the relevant information that they need to make informed decisions about whether to keep their current plan or examine other QHP options. Further, this approach potentially would reduce burden on health insurance issuers. As noted above, the Market Standards Rule requires that notices be provided in a form and manner

[1] CMS Insurance Standards Bulletin, Draft Notices When Discontinuing or Renewing a Product in the Group or Individual Market (March 14, 2014), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-discontinuance-renewal-notices-03-14-14.pdf .

specified by the Secretary. The guidance accompanying the standard notices that we are releasing for public comment contemporaneously with this proposed rule specifies that the form and manner may consist of standard notices developed by States that are enforcing the requirements of the Affordable Care Act, provided the State-developed notices are at least as protective as the standard Federal notices.

We recognize that the current notice requirements do not cover every situation in which an issuer may non-renew or discontinue coverage, consistent with the guaranteed renewability statute and regulations. For example, an issuer whose product no longer covers the service area of enrollees may non-renew those enrollees' coverage under that product. But, as long as the issuer's product continues to cover a majority of the same service area, the service area reduction would not trigger a product discontinuation and corresponding notice to affected enrollees under the current regulations. We also propose establishing a notice requirement that would apply to all plans subject to the guaranteed renewability requirements that non-renew 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. These notices would be provided in a form and manner specified by HHS. We solicit comments on this proposal, including the appropriate timeframe for providing the notice.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. 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, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing a summary of this proposed information collection for public comment. Interested persons are invited to send comments regarding this collection's proposed burden estimates or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have also submitted to the Office of Management and Budget (OMB) the proposed information collection for their emergency review. While the collection is necessary to ensure compliance with an initiative of the Administration, we are requesting emergency review under 5 CFR 1320(a)(2)(i) because public harm is reasonably likely to result if the regular clearance

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

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

Proposed §156.1255 would require that a health insurance issuer in the individual market that is renewing an enrollment group's coverage in a qualified health plan offered through the Exchange (including a renewal with modifications), or that is discontinuing a product 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 include certain information in the written notice specified in §147.106(c)(1) or (f)(1).

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 proposed provisions of this proposed 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 proposed rule.

For renewal notices, we estimate that, for each issuer, it would 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 would 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 would be 24 hours with an equivalent cost of approximately $1,277. For all 575 QHP issuers, the total burden would be 13,800 hours with an equivalent cost of approximately $705,479.

For re-enrollment (or discontinuance) notices, which could also be used in cases of other terminations or non-renewals, we estimate that, for each issuer, it would 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 the notice. We also estimate that it would take a computer programmer 9 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 would be 13 hours with an equivalent cost of approximately $649. For all 575 QHP issuers, the total annual burden would be 7,475 hours with an equivalent cost of approximately $373,237.

States that are enforcing the Affordable Care Act may develop their own 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 are requesting emergency OMB review with a 180-day approval period. Written comments and recommendations for this emergency request only will be considered from the public if received by the date and address noted below.

The proposed information collection requirement at §156.1255 is but one component of a broader information collection request. We are also soliciting comments for the aforementioned information collection request in a notice published elsewhere in this issue of the **Federal Register**. The notice provides the public with 30 days to submit comments. Copies of the supporting statement for this information collection request and any related forms can be found at: http://www.cms.hhs.gov/PaperworkReductionActof1995 or can be obtained by e-mailing your request, including your address, phone number, OMB number, and CMS document

identifier, to: Paperwork@cms.hhs.gov, or by calling the Reports Clearance Office at: 410-786-1326.

When commenting on this proposed information collection, please reference the CMS document identifier and the OMB control number. To be assured consideration, comments and recommendations must be received in one of the following ways by July 28, 2014:

1. Electronically. You may submit your comments electronically to http://www.regulations.gov. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. By regular mail. You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development

Attention: Document Identifier (CMS-10527)

Room C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

and,

OMB Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

New Executive Office Building, Room 10235

Washington, D.C. 20503

Fax Number: 202-395-6974

V. Regulatory Impact Statement

A. Summary

We are publishing this proposed 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 proposed 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 proposed 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 proposed 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 plan year 2015.

2. Summary of Impacts

It is expected that Exchanges will adopt an alternative method for annual eligibility redeterminations only if the related costs are no more than those associated with the process currently defined in §155.335. Therefore, we do not expect that there would be additional costs related to these provisions.

QHP issuers would incur costs to prepare and send renewal notices to comply with the proposed provisions, as detailed in section IV. States that choose to develop their own renewal notices would 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 plan 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 proposed 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 proposed rule would allow States to choose one of three methods for conducting annual redeterminations. We assume that States would choose an alternative method only if it is less costly than the current method. It would also require QHP issuers to include specific

information in renewal and re-enrollment notices sent to enrollees and issuers would incur costs to comply with this requirement. States that choose to develop their own notices would incur costs to do so. Consistent with policy embodied in UMRA, this proposed 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 would be preempted. State requirements that are more stringent than the Federal requirements would not be preempted by this proposed 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 proposed 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, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 155

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

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 proposes to amend 45 CFR parts 155 and 156 as set forth below:

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

1. 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).

2. Amend §155.330 to revise paragraph (b)(4) 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.

* * * * *

3. Amend §155.335 to revise paragraphs (a), (e), and (j) 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 plan 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 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 issuer through the Exchange that is the most similar to the enrollee's current product;

(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 QHP issuer in which the enrollee is eligible to enroll.

(iv) If the issuer does not offer any plan through the Exchange in which the enrollee is eligible to enroll, the enrollee will 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.

* * * * *

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

4. 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).

5. 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 discontinuing a product 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(c)(1) or (f)(1) of this subchapter:

(a) Premium and 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 with cost-sharing reductions, but for whom no QHP under the product remains available for renewal at the silver level, an explanation that unless the enrollment group selects a silver-level QHP through the Exchange, no cost-sharing reductions will be provided.

CMS-9941-P

Dated: June 19, 2014

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Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: __June 24, 2014___

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Sylvia M. Burwell,

Secretary.

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