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From: Mandy Cohen, Acting Director, Center for Consumer Information & Insurance Oversight

Title: Insurance Standards Bulletin Series – INFORMATION

Subject: Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market

I. Purpose

This bulletin provides draft standard notices that health insurance issuers would use when discontinuing or renewing coverage under a product in the small group or individual market. These draft notices take into account comments received in response to initial draft notices that were contained in a bulletin released by the Centers for Medicare & Medicaid Services (CMS) on March 14, 2014.¹ These draft notices also take into account content described in the proposed rule released today 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*.

Comments on the revised draft notices CMS is releasing today may be submitted as described in section IV of this bulletin. CMS intends to finalize these notices in conjunction with the *Annual Eligibility Redeterminations* final rule based on the results of consumer testing and input from the public comment period. CMS will consider issuers that use either these draft notices or the

¹ The March 14, 2014 bulletin (*Draft Notices When Discontinuing or Renewing a Product in the Group or Individual Market*) was issued concurrently with proposed regulations that, among other requirements, set forth notice requirements for issuers when discontinuing or renewing coverage in the group or individual market (79 FR 15808). The final regulations at 45 CFR 146.152(h), 147.106(f), and 148.122(i) establish that the renewal notice requirements apply only to issuers in the individual and small group markets (79 FR 30240).

final standard Federal notices to have met the Secretary's specification regarding the form and manner of the required discontinuance and renewal notices in case where the State does not develop and require the use of a different form consistent with this bulletin, at least through September 30, 2015.

II. Background

The Public Health Service (PHS) Act requires health insurance issuers offering health insurance coverage in the group and individual markets, through or outside of an Exchange (also referred to as a Health Insurance Marketplace or Marketplace), to guarantee the renewal of coverage unless at least one of several listed exceptions applies. This requirement applies to products with grandfathered health plans and products with non-grandfathered health plans. (See PHS Act sections 2703, 2712 (as codified prior to enactment of the Affordable Care Act), and 2742). One exception to the guaranteed renewability requirement permits an issuer to cease offering a particular product in the large group, small group, or individual market and to discontinue existing blocks of business with respect to that product. This may be done, in accordance with applicable State law, as long as the issuer meets all of the following requirements:

- Provides written notice to each plan sponsor or individual provided that particular product (and to all participants and beneficiaries covered under such coverage);
- Offers to each plan sponsor or individual provided that particular product the option to purchase, on a guaranteed availability basis, any other coverage offered by the issuer in that market; and
- Acts uniformly without regard to the claims experience or any health status-related factor relating to individuals when discontinuing that product and offering the option of other coverage.

The PHS Act also contains an exception to the guaranteed renewability requirements for “uniform modifications of coverage.” These provisions permit an issuer to modify the health insurance coverage for a product offered to a group health plan or an individual only at the time of coverage renewal. For small group and individual market coverage, the modification must be consistent with State law and effective uniformly for all group health plans or individuals with that product. (See PHS Act sections 2703(d), 2712(d) (as codified prior to enactment of the Affordable Care Act), and 2742(d)).²

² On May 27, 2014, CMS published final rules specifying when a modification to a health insurance product is a uniform modification, as opposed to a product discontinuance. *See Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond* (79 FR 30240).

We note that if a qualified health plan (QHP)³ is decertified or not recertified for sale through the Marketplace, the coverage must be guaranteed renewable outside the Marketplace at the option of the plan sponsor or individual (as applicable), unless the issuer has withdrawn from the applicable market entirely, has withdrawn the entire product from the market, or another exception applies.

On May 27, 2014, CMS published a final rule entitled *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond* (79 FR 30240). Under the guaranteed renewability statute and final regulations, written notices of product discontinuance must be provided to each plan sponsor or individual, as applicable, provided that particular product (and to all participants and beneficiaries covered under such coverage) at least 90 calendar days before the date the coverage will be discontinued. The discontinuation notices must be provided in a form and manner specified by the Secretary of Health and Human Services (the Secretary).

With respect to product renewals, including renewals with uniform modifications, for non-grandfathered coverage in the individual market, an issuer must provide to each individual market policyholder written notice of renewal before the first day of the next annual open enrollment period. Issuers of individual market coverage offered through the Marketplace should not send the written notices of renewal until their QHP Issuer Agreements for the applicable plan year have been signed, to ensure that the correct information is included.

For grandfathered coverage in the individual market, and grandfathered and non-grandfathered coverage in the small group market, an issuer must provide to each plan sponsor or individual, as applicable, written notice of renewal at least 60 calendar days before the date of the renewal of the coverage. The renewal notices also must be provided in a form and manner specified by the Secretary.

III. Form and Manner of Required Notices

This section describes the form and manner of the notices that would be specified by the Secretary for product discontinuations and renewals in the large group, small group, and individual markets, in accordance with 45 CFR 146.152, 147.106, and 148.122.

Large Group Market

³ When referring to QHPs in this context, we are not referring to stand-alone dental QHPs, which are excepted benefits and therefore not subject to the guaranteed renewability requirements.

With respect to grandfathered and non-grandfathered products in the large group market, issuers would be permitted to use any form and manner otherwise permitted by applicable laws and regulations to notify large employers of large group product discontinuances. The requirement to provide notices of renewals does not apply to renewals of large group products.

Small Group Market and Individual Market

With respect to grandfathered and non-grandfathered products in the small group and individual markets, issuers generally would be required to provide the required discontinuance and renewal notices in the form of Federal standard notices. The Federal standard notices are being issued in draft format at this time.

The notices of renewal should include information about premiums and any advance payments of the premium tax credit for the renewed plan in the next plan or policy year, information about changes to the plan, information about other health coverage options, and contact information for the consumer to call with questions. The notices of discontinuation should include a statement that the coverage is being discontinued, information about other health coverage options, and contact information for the consumer to call with questions. The renewal and discontinuation notices also should contain any content required by the *Annual Eligibility Redeterminations* final rule.

Under proposed 45 CFR §156.1255 of the *Annual Eligibility Redeterminations* proposed rule, a health insurance issuer in the individual market that is renewing an enrollment group's coverage in a QHP offered through the Marketplace (including a renewal with modifications), or that is discontinuing a product that includes plans offered through the Marketplace and, consistent with State law, automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Marketplace, would be required to include certain information in the applicable renewal and discontinuance notices. This includes, "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." For the Federally-facilitated Marketplace and any State Marketplace that does not provide such information to enrollees or does not require issuers to provide such information to enrollees, this information would include the following:

- The monthly premium for the enrollment group in 2015;
- The most recent monthly amount of any APTC paid for the enrollment group in 2014 (if applicable); and
- For any enrollment group for which advance payments are being provided, the difference between the total monthly premium for the renewed or uniformly modified plan in 2015

and the most recent monthly amount of the APTC paid for the enrollment group in 2014 which represents the enrollment group's share of total premium if APTC were continued at the most recent 2014 level in 2015 (if applicable).

We note that consistent with 45 CFR §§156.250 and 155.230(b), QHP issuer notices must conform to the standards in 45 CFR §155.205(c), which addresses accessibility. In addition to these regulations, certain Federal civil rights laws, such as Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, also may apply. These Federal civil rights laws apply to entities that receive federal financial assistance, and impose nondiscrimination obligations with respect to persons with disabilities and address the communications needs of persons who have limited English proficiency.

States that are enforcing the Affordable Care Act⁴ may, without obtaining further approval from CMS, develop their own standard notices for product discontinuances, renewals of coverage, or both, provided the State-developed notices are at least as protective as the Federal standard notices, once finalized. In such cases, issuers of small group and individual products: (1) must provide notices in the form of the State's standard discontinuance and renewal notices, if required by the State, (2) may provide notices in the form of either the State's standard discontinuance and renewal notices or the Federal standard notices, as permitted by the State.

The following factors would have to be considered in determining whether a State-developed form of the required notices is at least as protective as the Federal standard notices, once finalized:

- The notice clearly explains the options for the employer or individual for obtaining or renewing health insurance coverage both through inside and outside of the Marketplace.
- The notice is written in a clearly understandable manner.
- The notice contains all of the information outlined earlier in this bulletin.

We received a number of comments on the March 14, 2014, draft notices regarding concerns about adequately describing variations in State law and maintaining the role of States as the primary regulators of health insurance coverage. We believe this approach will help ensure better information for consumers, while allowing for flexibility so that States can adequately account for their State-specific consumer protections. We request comment on the approach to State-developed notices and whether this approach provides sufficient flexibility for States, while ensuring that issuers provide sufficient information for consumers.

⁴ Currently, Alabama, Missouri, Oklahoma, Texas, and Wyoming have informed HHS that they are not enforcing the Affordable Care Act in their jurisdictions. These are considered "non-enforcing" States. All other States are currently considered by HHS to be enforcing the Affordable Care Act.

Health insurance issuers in non-enforcing States and issuers in enforcing States that decline to develop their own forms of notices would be required to use the applicable Federal standard notices. If the Federal standard notices are used, they could not be modified in any way, except where customization is allowed in the brackets.

- Attachment 1 is the Federal standard renewal notice for the individual market where coverage is being renewed outside the Marketplace (including when a QHP is not recertified, but coverage is being renewed outside the Marketplace).
- Attachment 2 is the Federal standard renewal notice for the individual market where coverage is being renewed in a QHP offered through the Marketplace. This would be required if the *Annual Eligibility Redeterminations* proposed rule is finalized as proposed.
- Attachment 3 is the Federal standard discontinuance notice for the individual market outside the Marketplace.
- Attachment 4 is the Federal standard discontinuance notice for the individual market where coverage being discontinued was in a QHP offered through the Marketplace. This would be required for discontinuances and other non-renewals if the *Annual Eligibility Redeterminations* proposed rule is finalized as proposed.
- Attachment 5 is the Federal standard renewal notice to employers for the small group market.
- Attachment 6 is the Federal standard discontinuance notice to employers for the small group market. Although a discontinuance notice also is required to be provided to all covered participants and beneficiaries, pursuant to 45 CFR §§ 146.152(c)(1) and 147.106(c)(1), this bulletin does not include a Federal standard discontinuance notice to covered participants and beneficiaries of employers in the small group market. Issuers of small group products would be permitted to use any form and manner otherwise permitted by applicable laws and regulations for this purpose.

We solicit comment on whether to develop a different form and manner for renewal and discontinuation notices for coverage offered through the Small Business Health Options Program (SHOP) Marketplace from the form and manner of the draft notices attached to this bulletin for the small group market outside the SHOP. For example, we recognize that certain aspects of employee choice in the SHOP may conflict with renewals of coverage at a different metal level. We specifically request comments on how to address employee choice and other unique features of the SHOP in the notices.

Student Health Insurance Coverage

The discontinuation and renewal notice requirements apply to student health insurance coverage as a type of individual market coverage. However, pursuant to 45 CFR 147.145(b), a health insurance issuer that offers student health insurance coverage is not required to establish open

enrollment periods that are based on a calendar policy year. Accordingly, CMS expects issuers of non-grandfathered student health insurance coverage to provide notice at least 60 calendar days before the date the coverage will be renewed, rather than before the first day of the next annual open enrollment period. We invite comment on whether additional steps are needed to inform students of their options.

Transitional Plans

With respect to health insurance coverage that is renewed under the transitional policy announced in November 2013 and extended in March 2014,⁵ issuers must provide renewal notices in the form of the notices specified in the March 5, 2014 guidance, in lieu of the form and manner specified in this bulletin. These notices must be provided at least 60 calendar days before the date the coverage will be renewed, consistent with the requirements of 45 CFR 146.152 and 148.122, as applicable. Health insurance issuers that discontinue coverage offered under the HHS transitional policy would be required to provide discontinuance notices in the form and manner specified in this bulletin.

U.S. Territories

The draft notices attached to this bulletin are not designed for use by issuers in the U.S. Territories, which may not have a Health Insurance Marketplace. We solicit comments on whether the notices should be modified to be applicable to issuers in the U.S. Territories, or whether issuers in the U.S. Territories should be permitted to use any form and manner otherwise permitted by applicable laws and regulations for this purpose.

IV. Request for Comments and Reliance Period

We are requesting comments on the specific issues identified in this bulletin and on the draft notices contained in this bulletin. Comments must be submitted by July 17, 2014 and may be submitted electronically to: marketreform@cms.hhs.gov.

CMS intends to finalize these notices based on the results of consumer testing and input from the public comment period, and intends to issue final guidance in conjunction with the *Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges* final rule. CMS will consider issuers that use either these draft notices or the final standard Federal notices to have met the Secretary's specification regarding the form and manner

⁵ Letter to Insurance Commissioners on Market Transitional Policy (November 14, 2013), available at: <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>. Extended Transition to Affordable Care Act-Compliant Policies (March 5, 2014), available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

of the required discontinuance and renewal notices in cases where the State does not develop and require the use of a different form consistent with this bulletin, at least through September 30, 2015.

Where to get more information:

If you have any questions about this bulletin, please e-mail CCIIO at marketreform@cms.hhs.gov.

Attachment 1 – Renewal notice for the individual market where coverage is being renewed outside the Marketplace.

Important: We're Continuing to Offer Your Health Coverage.

Dear [Policyholder or Name¹],

Your health insurance coverage is coming up for renewal. **On [Date²], you will be automatically re-enrolled and can keep your current coverage.** Below are changes we'll be making to your plan and options to consider to possibly lower your costs or choose a new plan.

Changes we're making to your current health plan

- Premium – Your new premium starts in [Month³]. Your monthly premium will be \$[Dollar amount⁴]. **Check to see if you have other options or can get a tax credit at: [State Marketplace website/HealthCare.gov⁵]**
- [List changes to renewed plan, including:
- Name of new plan and Plan ID
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan⁶].

This plan isn't being offered through [State Marketplace Name/the Marketplace⁷]. If you qualify for lower costs on monthly premiums or lower out-of-pocket costs, you can get those savings only if you enroll in a plan through [State Marketplace Name/the Marketplace⁸].

What if I want to change plans?

- The 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015. If you want a new plan with coverage that starts on January 1, 2015, the deadline to enroll is [Date⁹].
- You may be able to choose a new health plan from [Issuer name¹⁰] or another insurance company through [State Marketplace Name/the Marketplace¹¹]. You or your family may also qualify for Medicaid or the Children's Health Insurance Program (CHIP).
- You can choose to buy a new health plan outside [State Marketplace Name/the Marketplace¹²]**—**directly from an insurance company or with the help of an agent or broker. But remember: If you qualify for lower costs, you can get those savings **only** if you enroll through [State Marketplace Name/the Marketplace¹³].

What else should I look at before deciding to keep or change my plan?

Call or visit the plan's website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered.

Questions?

Attachment 1 – Renewal notice for the individual market where coverage is being renewed outside the Marketplace.

- Call [Issuer Name and Contact Information and Hours of Operation¹⁴].
- Visit [State Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325)¹⁵] to learn more about [State Marketplace Name/the Health Insurance Marketplace¹⁶].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer Contact Information].¹⁷

Important: We're Continuing to Offer Your Health Coverage.

Dear [Policyholder or Name¹],

Your health insurance coverage is coming up for renewal. **On [Date²], you will be automatically re-enrolled and can keep your current coverage.**

In 2014, you saved \$[Dollar amount³] each month because of a tax credit. However, you might be able to get a bigger tax credit or better plan for your budget by visiting [State Marketplace Name/the Marketplace⁴] during Open Enrollment. The 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015.

Last Year You Saved Each Month	
\$[Dollar amount⁵]	Go to: [State Marketplace website/HealthCare.gov ⁶]

Below are changes we'll be making to your plan and options to consider to possibly lower your costs or choose a new plan.

Changes we're making to your current health plan

- Premium – Your new premium starts in January. You'll pay \$[Dollar amount⁷] each month. This amount is based on any premium tax credit you received for the 2014 plan year, which lowers your monthly premium from \$[Dollar amount⁸]. **Check to see if you have other options or can get a bigger tax credit at: [State Marketplace website/HealthCare.gov⁹]**
- [List changes to renewed plan, including:
- Name of new plan and Plan ID
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan¹⁰].

If you qualify for lower out-of-pocket costs, make sure you enroll in a plan in the Silver category through [State Marketplace name/the Marketplace¹¹] to get these savings (except for members of federally recognized Indian tribe and Alaska Natives).

[Important information about your tax credit

Last year, the tax credit that lowered your monthly premium was [Dollar amount¹³]. To make sure you get the full savings you deserve, you must update your information with [State Marketplace Name/the Marketplace¹⁴]. You can do this online, in person, or by phone. This will help make sure you get the right premium tax credit amount and don't owe money on your next tax return because your household size, income, or other eligibility information was different

Attachment 2 – Renewal notice for the individual market where coverage is being renewed in a QHP offered through the Marketplace

than you estimated. Your final tax credit is determined when you file your federal income tax return for the year.^{12]}

[If you didn't receive a tax credit in 2014

Tax credits and other cost savings are available to most people who have a [State Marketplace Name/Marketplace^{16]} plan. To find out if you qualify, go to [State Marketplace website/HealthCare.gov^{17]}.^{15]}

If you go back to update your [State Marketplace Name/the Marketplace^{18]} application and want to keep this plan, make sure you choose [Plan name and Plan ID^{19]} again.

What if I want to change plans?

- The 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015. If you want a new plan with coverage that starts on January 1, 2015, the deadline to enroll is [Date^{20]}.
- You may be able to choose a new health plan from [Issuer name^{21]} or another insurance company through [State Marketplace Name/the Marketplace^{22]}. You or your family may also qualify for Medicaid or the Children's Health Insurance Program (CHIP).
- You can choose to buy a new health plan outside [State Marketplace Name/the Marketplace^{23]}—directly from an insurance company or with the help of an agent or broker. But remember: If you qualify for lower costs, you can get those savings **only** if you enroll through [State Marketplace Name/the Marketplace^{24]}.

What else should I look at before deciding to keep or change my plan?

Call or visit the plan's website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered.

Questions?

- Call [Issuer Name and Contact Information and Hours of Operation^{25]}.
- Visit [State Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325)^{26]} to learn more about [State Marketplace Name/the Health Insurance Marketplace^{27]}.

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer Contact Information].^{28]}

**Important: We Will Not Offer Your Health Coverage Next Year.
But You Have Options for New Coverage.**

Dear [Policyholder or Name¹],

We have decided not to offer your current health coverage again next year. Your current coverage will end on [Date²]. This means **you must choose a new plan to have health insurance coverage**. This letter explains the options available to you.

Options from [Issuer Name³]

[We have selected a new [Issuer Name⁵] plan for you that's similar to your current plan. **You'll be automatically enrolled in [Plan Name and Plan ID⁶] unless you choose another option by [Date⁷].** Below are key differences from your current plan. You can review all the benefits and coverage for this plan at [Issuer website⁸].

- Premium – Your new premium starts in January. You'll pay \$[Dollar amount⁹] each month. **Check to see if you have other options or can get a tax credit at: [State Marketplace website/HealthCare.gov¹⁰]**
- [List changes to new plan, including:
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan¹¹].

This plan isn't being offered through [State Marketplace Name/the Marketplace¹²]. If you qualify for lower costs on monthly premiums or lower out-of-pocket costs, you can get those savings only if you enroll in a plan through [State Marketplace Name/the Marketplace¹³].

If you want this plan, simply pay the plan premium. If not, you can also choose any of our other plans available to you.⁴

[You can choose any individual coverage offered by [Issuer Name¹⁵] in your service area. Visit [Issuer website¹⁶], or call [Issuer phone number¹⁷] to learn about the plans available to you.¹⁴]

What other options do I have?

- You may be able to choose a new health plan from [Issuer name¹⁸] or another insurance company through [State Marketplace Name/the Marketplace¹⁹]. You or your family may also qualify for Medicaid or the Children's Health Insurance Program (CHIP).
- You can choose to buy a new health plan outside [State Marketplace Name/the Marketplace²⁰]²⁰—directly from an insurance company or with the help of an agent or broker. But remember: If you qualify for lower costs, you can get those savings **only** if you enroll through [State Marketplace Name/the Marketplace²¹].

What else should I look at before deciding?

Call or visit the plan's website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered.

When do I need to make a decision?

Because we are ending your plan, you qualify for a special enrollment period that lets you enroll in an individual plan. To avoid a gap in coverage, enroll in a new plan by the last day of your current plan and coverage can begin on the 1st of the following month. In addition, the 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015.

Questions?

- Call [Issuer Name and Contact Information and Hours of Operation²²].
- Visit [State Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325)²³] to learn more about [State Marketplace Name/the Health Insurance Marketplace²⁴].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer Contact Information].²⁵

**Important: We Will Not Offer Your Health Plan Next Year.
But You Have Options for New Coverage.**

Dear [Policyholder or Name¹],

We have decided not to offer your current health coverage again next year. Your current coverage will end on [Date²]. This means **you must choose a new plan to have health insurance coverage**. This letter explains the options available to you.

In 2014 you saved \$[Dollar amount³] each month because of a tax credit. However, you might be able to get a bigger tax credit or better plan for your budget by visiting [State Marketplace Name/the Marketplace⁴] during Open Enrollment. The 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015.

Last Year You Saved Each Month	
[\$Dollar amount⁵]	Go to: [State Marketplace website/HealthCare.gov ⁶]

Options from [Issuer Name⁷]

[We have selected a new [Issuer Name⁹] plan for you that's similar to your current plan. **We'll automatically enroll you in [Plan Name and Plan ID¹⁰] unless you choose another option.** Below are key differences from your current plan. You can review all the benefits and coverage for this plan at [Issuer website¹¹].

- Premium – Your new premium starts in January. You'll pay \$[Dollar amount¹²] each month. This amount is based on any premium tax credit that you received for the 2014 plan year, which lowers your monthly premium from \$[Dollar amount¹³]. **Check to see if you have other options or can get a bigger tax credit at: [State Marketplace website/HealthCare.gov¹⁴]**
- [List changes to new plan, including:
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan¹⁵].

[This plan isn't being offered through [State Marketplace Name/the Marketplace¹⁷]. If you qualify for a tax credit, make sure you choose a plan through [State Marketplace Name/the Marketplace¹⁸] to receive these savings. Also, if you qualify for lower out-of-pocket costs, make sure you enroll in a plan in the Silver category through [State Marketplace name/the Marketplace¹⁹] to get these savings (except for members of federally recognized Indian tribe and Alaska Natives)¹⁶].

Attachment 4 – Discontinuation notice for the individual market where coverage being discontinued was in a QHP offered through the Marketplace

[If you go back to update your [State Marketplace Name/the Marketplace²⁰] application at and want to keep this plan, you will need to choose [Plan name and Plan ID²¹].²²] ⁸

[You can choose any other individual coverage [Issuer name]²⁴ offers in your service area. Visit [Issuer website²⁵], or call [Issuer phone number²⁶] to learn about the plans available to you.²³]

[Important information about your tax credit

Last year, the tax credit that lowered your monthly premium was [Dollar amount²⁸]. To make sure you get the full savings you deserve, you must go to [State Marketplace Name/the Marketplace²⁹] to update your information. You can do this online, in person, or by phone. This will help make sure you get the right premium tax credit amount and don't owe money on your next tax return because your household size, income or other eligibility information was different than you estimated. Your final tax credit is determined when you file your federal income tax return for the year.²⁷]

[If you didn't receive a tax credit in 2014

Tax credits and other cost savings are available to most people who have a [State Marketplace Name/ Marketplace³¹] plan. To find out if you qualify, go to [State Marketplace website/HealthCare.gov³²]³⁰].

What other options do I have?

- You may be able to choose a new health plan from [Issuer name³³] or another insurance company through [State Marketplace Name/the Marketplace³⁴]. You or your family may also qualify for Medicaid or the Children's Health Insurance Program (CHIP).
- You can choose to buy a new health plan outside [State Marketplace Name/the Marketplace³⁵]—directly from an insurance company or with the help of an agent or broker. But remember: If you qualify for lower costs, you can get those savings **only** if you enroll through [State Marketplace Name/the Marketplace²⁸].

What else should I look at before deciding?

Call or visit the plan's website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered.

When do I need to make a decision?

Because we are ending your plan, you qualify for a special enrollment period that lets you enroll in an individual plan. To avoid a gap in coverage, enroll in a new plan by the last day of your current plan and coverage can begin on the 1st of the following month. In addition, the 2015 Open Enrollment period is from November 15, 2014 to February 15, 2015.

Questions?

- Call [Issuer Name and Contact Information and Hours of Operation³⁶].

Attachment 4 – Discontinuation notice for the individual market where coverage being discontinued was in a QHP offered through the Marketplace

- Visit [State Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325)³⁷] to learn more about [State Marketplace Name/the Health Insurance Marketplace³⁸].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer contact information].³⁹

Important: We're Continuing to Offer Your Group Health Coverage.

Dear [Plan Sponsor or Name¹],

Your group health insurance coverage is coming up for renewal. **On [Date²], your group members will be automatically re-enrolled and can keep your group's current coverage.** Below are changes we'll be making to the plan and options to consider to possibly lower your costs or choose a new plan.

Changes we're making to your group's current coverage

- Premium – Your new premium starts in [Month³]. Your monthly premium will be \$[Dollar amount⁴]. This is an estimate based on current enrollment. This amount may change depending on the individuals who actually enroll in the plan. **Check to see if you have other options at: [State Marketplace website/HealthCare.gov⁵**
- [List changes to renewed plan, including:
- Name of new plan and Plan ID
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan⁶].

[This plan isn't being offered through [State SHOP Marketplace Name/the Small Business Health Options (SHOP) Marketplace⁸]. If you're eligible for a small business health care tax credit, you usually can get that credit only if you buy insurance through [State SHOP Marketplace Name/ the SHOP Marketplace⁹]⁷].

What if I want to change plans?

- You may be able to choose a new health plan, or offer your employees a choice of plans, through different insurance companies, through [State SHOP Marketplace Name/the SHOP Marketplace¹⁰]. If you have fewer than 25 full-time-equivalent employees, you might qualify for a small business health care tax credit if you buy insurance through [State SHOP Marketplace Name/the SHOP Marketplace¹¹].
- You can choose to buy a new health plan outside [State SHOP Marketplace Name/the SHOP Marketplace¹²]¹²—directly from an insurance company or with the help of an agent or broker. But remember: If you're eligible for a small business health care tax credit, you usually can get that credit **only** if you buy a plan through [State SHOP Marketplace Name/the SHOP Marketplace¹³].
- You generally can buy coverage any time. If group members enroll by the [Day¹⁴] of the month, coverage can begin on the 1st of the following month.

What else should I look at before deciding to keep or change my plan?

Call or visit the plan's website to check which doctors, other health care providers, and prescription medications are covered by the plan. This is an important step when choosing a plan that meets the needs of your group members.

Questions?

- Call [Issuer Name and Contact Information and Hours of Operation¹⁵].
- Visit [State SHOP Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-706-7893 (TTY: 1-800-706-7915)¹⁶] to learn more about [State SHOP Marketplace Name/the Health Insurance Marketplace¹⁷].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer contact information].¹⁸

Important: Your Group Health Coverage Will Not Be Available Next Year.

Dear [Plan Sponsor or Name¹],

We have decided not to offer your group's current health coverage again next year. The current coverage will end on [Date²]. This means **you may need to choose a new plan for your group members to have health insurance coverage**. This letter explains the options available to you.

Options from [Issuer Name³]

[We have selected a new [Issuer Name⁵] plan for your group members that's similar to their current plan. **We'll automatically enroll your group members in [Plan Name and Plan ID⁶] unless you choose another option.** Below are key differences between the new coverage and the current coverage. You can review all the benefits and coverage for this plan at [Issuer website⁷]].

- Premium – Your new premium starts in [Month⁸]. Your monthly premium will be \$[Dollar amount⁹]. This is an estimate based on current enrollment. This amount may change depending on the individuals who actually enroll in the plan. **Check to see if you have other options at: [State SHOP Marketplace website/HealthCare.gov¹⁰]**
- [List changes to new plan, including:
- Benefit changes
- Cost-sharing changes, including whether the plan is a different metal level from the previous plan¹¹].

You can also choose any of our other small group plans available to you.⁴

[You can choose any other small group coverage offered by [Issuer name¹³]. Call [Issuer phone number¹⁴] or visit [Issuer website¹⁵] to learn about plans available to you.¹²

What other options do I have?

- You may be able to choose a new health plan, or offer your employees a choice of plans, through different insurance companies, through [State SHOP Marketplace Name/the SHOP Marketplace¹⁶]. If you have fewer than 25 full-time-equivalent employees, you might qualify for a small business health care tax credit if you buy insurance through [State SHOP Marketplace Name/the SHOP Marketplace¹⁷].
- You can choose to buy a new health plan outside [State SHOP Marketplace Name/the SHOP Marketplace¹⁸—directly from an insurance company or with the help of an agent or broker. But remember: If you're eligible for a small business health care tax credit, you usually can get that credit **only** if you buy a plan through [State SHOP Marketplace Name/the SHOP Marketplace¹⁹].

What else should I look at before deciding?

Call or visit the plan’s website to check which doctors, other health care providers, and prescription medications are covered by the plan. This is an important step when choosing a plan that meets the needs of your group members.

When do I need to make a decision?

You generally can buy coverage any time. If group members enroll by the [Day²⁰] of the month, coverage can begin on the 1st of the following month.

We are notifying your employees

Federal law requires that we notify all group members with this coverage that it is no longer being offered. Because we might not know about other coverage decisions you have made, we’ll tell your employees to check with the plan sponsor or administrator about coverage options that might be available through your organization.

Questions?

- Call [Issuer Name and Contact Information and Hours of Operation²¹].
- Visit [State SHOP Marketplace website and Consumer Assistance Information/HealthCare.gov or call 1-800-706-7893 (TTY: 1-800-706-7915)²²] to learn more about [State SHOP Marketplace Name/the Health Insurance Marketplace²³].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer contact information].²⁴