DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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From: Peter Nelson, Deputy Administrator and Director, Center for Consumer Information & Insurance Oversight

Subject: Enforcement Safe Harbors Related to Federal Standard Renewal and Product Discontinuation Notices; 90-Day Product Discontinuation Notice Requirement in the Individual Market for Coverage in the 2026 Benefit Year

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is publishing this guidance to provide individual market qualified health plan (QHP) issuers with flexibility, if permitted by applicable state authorities, to use modified Federal standard notices of product discontinuation and renewal in connection with the open enrollment period for coverage in the 2026 benefit year, given the significant changes to advance payments of the premium tax credit (APTC) for the 2026 benefit year.

In addition, this guidance provides a safe harbor from enforcement by CMS under certain conditions, in connection with the open enrollment period for coverage in the 2026 benefit year, with respect to the requirement to provide at least 90 days' notice of a product discontinuation in the individual market.

II. Enforcement Safe Harbor for Federal Standard Notices in Connection with the Open Enrollment Period for Coverage through the Individual Market Exchanges in the 2026 Benefit Year

Under the guaranteed renewability requirements of title XXVII of the Public Health Service Act (PHS Act) and their implementing regulations, a health insurance issuer that discontinues or renews a product[1] in the group or individual market through or outside of an Exchange (also referred to as a Health Insurance Marketplace®[2]) or Marketplace (including a renewal with uniform modifications[3]), or that non-renews or terminates coverage in the group or individual market through or outside of an Exchange based on movement of all enrollees in a plan or policy outside the product's service area, must provide written notice in a form and manner specified by the Secretary of Health and Human Services (the Secretary).[4]

[1] The terms "product" and "plan" are defined by regulation at 45 CFR 144.103.
[2] Health Insurance Marketplace® is a registered trademark of the U.S. Department of Health & Human Services.
[3] 45 CFR 146.152(f), 147.106(e), and 148.122(g).
[4] The requirement to provide notices of renewal applies to issuers in the individual and small group markets. The requirement to provide notices of product discontinuation and notices of non-renewal or termination based on enrollees'

Under QHP issuer regulations at 45 CFR 156.1255, a health insurance issuer must include certain information in the applicable renewal and discontinuation notices for an individual market QHP, including, among other things, premium and APTC information sufficient to notify the enrollment group of its expected monthly premium payment under the coverage for the upcoming policy year.[5] This regulation addresses situations in which an issuer (1) is renewing an enrollment group's coverage in an individual market QHP offered through an Exchange (including a renewal with uniform modifications), or (2) is non-renewing or terminating coverage based on a discontinuance of the product or there no longer being any enrollee in the plan who lives, resides, or works within the product's service area, and which, consistent with applicable state law, requires automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange in accordance with 45 CFR 155.335(j).

In completing the notices, QHP issuers are instructed to inform enrollees of their upcoming benefit year premium net of APTC, and to provide the current benefit year's premium net of APTC for comparison. The issuer must use the actual monthly amount of premium for the upcoming benefit year. For APTC for the upcoming benefit year, the issuer is directed to use either the auto-redetermined amount sent by the Exchange or the current year's APTC as an estimate. If the Exchange has completed the annual eligibility redetermination process by the time a QHP issuer provides the notice, QHP issuers are instructed to populate the notices with the actual amount of monthly premium for the enrollment group for the upcoming benefit year, and the amount of APTC sent in the redetermination transaction from the Exchange. CMS strongly encourages QHP issuers to use the amount of APTC sent in the auto-redetermination transaction if they have the capability to do so. However, CMS recognizes that many QHP issuers begin developing their notices far in advance of when the Exchanges complete the annual eligibility redetermination, making it operationally unfeasible to use the amount of APTC sent in the redetermination transaction for the upcoming benefit year.

For these QHP issuers, the current version of the Federal standard notices for renewal and re-enrollment in QHPs through Exchanges[6] requires QHP issuers to notify the enrollment group of its expected monthly premium payment under the coverage for the upcoming policy year using estimates that are based on the actual upcoming plan year's premium and the estimated amount of APTC, which is presumed to be the same amount of APTC received in the current benefit year. However, enhanced premium tax credits that were initially authorized in the American Rescue Plan of 2021 (ARP) and extended through the Inflation Reduction Act of 2022 (IRA), are set to expire on

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movement outside the service area applies to issuers in the individual, small group, and large group markets. These requirements are imposed pursuant to the PHS Act section 2703, as added by the Patient Protection and Affordable Care Act (ACA), and sections 2712 (former) and 2742, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as implemented in regulations at 45 CFR 146.152, 147.106, and 148.122, respectively. For ease of reference, we refer in this guidance only to the requirements codified in section 2703 and §147.106, but references to section 2703 and §147.106 should be considered to include references to the applicable sections of all three statutes and regulations.

[5] 45 CFR 156.1255(a)-(d).

[6] See Attachments 2 and 4, Updated Federal Standard Renewal and Product Discontinuation Notices in the Individual Market (Required for Notices Provided in in Connection with the Open Enrollment Period for Coverage in the Individual Market in the 2024 Benefit Year, available at https://www.cms.gov/files/document/updated-federal-standard-notices-and-enforcement-safe-harbor-discontinuation-notices-py-2024.pdf. The Federal standard notices and the related burden are currently approved under OMB Control Number 0938-1254 (CMS-10527).

December 31, 2025, under current law. Thus, basing the 2026 benefit year estimate of APTC on the current plan year's amount of APTC will likely produce significantly inflated estimates of APTC, potentially misleading consumers about the amount of APTC they will receive and their net monthly premium for the 2026 benefit year. Therefore, similar to previously issued guidance associated with the 2023 plan year,[7] this guidance announces enforcement discretion with respect to the Federal standard notices for renewal and re-enrollment in individual market QHPs offered through Exchanges to allow issuers, if permitted by applicable state authorities, to omit information about premium and APTC in connection with the open enrollment period for coverage for the 2026 benefit year.

Accordingly, CMS will not take enforcement action against an issuer for omitting premium and APTC information from the Federal standard notices that issuers are required to send to Exchange enrollees pursuant to 45 CFR 156.1255. This non-enforcement policy is limited to notices provided in connection with the open enrollment period for coverage in an individual market QHP for the 2026 benefit year. CMS is in the process of revising the Federal standard notices to incorporate the necessary language modifications due to the changes finalized in the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability final rule.[8] Issuers are encouraged to implement such updated notices once the revised notices are approved by the Office of Management and Budget (OMB). To accommodate issuers facing operational constraints, the version of the standard notices[9] published in July 2023 for the 2024 benefit year) remain valid for use for the 2026 benefit year (without the premium and APTC information) even after the updated notices become available.

Issuers must continue to use the currently approved Federal standard notices when providing renewal and discontinuation notices that do not involve an enrollment or renewal in individual market coverage through the Exchange.

States and Exchanges are encouraged to adopt a similar approach to enforcement. CMS will not consider a state or an Exchange to have failed to substantially enforce requirements regarding renewal and re-enrollment notices because the state adopts such an approach.

Consistent with previous guidance, in cases where a state develops and requires the use of a different form consistent with CMS guidance, issuers in that state will be required to use notices in the form and manner specified by the state.

III. Enforcement Safe Harbor for Product Discontinuation Notices in Connection with the Open Enrollment Period for Coverage in the Individual Market in the 2026 Benefit Year

[7] Enforcement Safe Harbors related to Federal Standard Renewal and Product Discontinuation Notices; 90-Day Product Discontinuation Notice Requirement in the Individual Market (Jun. 22, 2022), available at https://www.cms.gov/files/document/safe-harbors-related-federal-standard-renewal-and-product-discontinuation-notices.pdf.

[8] 90 FR 27074 (June 25, 2025).

[9] See https://www.cms.gov/files/document/updated-federal-standard-notices-and-enforcement-safe-harbor-discontinuation-notices-py-2024.pdf

Under the guaranteed renewability provisions of title XXVII of the PHS Act and their implementing regulations,[10] a health insurance issuer that elects to discontinue offering a particular product (as defined in 45 CFR 144.103) in the group or individual market must provide notice of such discontinuation at least 90 calendar days prior to the date of the discontinuation. The purpose of this requirement is to inform consumers that their current health coverage is being terminated and that they have other health coverage options.

Due to the timing of QHP certification for each of the 2015 through 2025 benefit years, issuers were in many instances unable to finalize their plan offerings until closer to the start of the annual open enrollment period, after the deadline to meet the 90-day product discontinuation notice requirement. This meant consumers could potentially receive product discontinuation notices without being able to take prompt action to shop for new coverage, and issuers would not have been able to suggest replacement coverage options, as explicitly envisioned by the discontinuation notices. Therefore, in connection with the open enrollment period for coverage in each of these benefit years, CMS announced that it would not take enforcement action against an issuer for failing to meet the 90-day notice requirement in the individual market, under certain conditions.[11]

Consistent with previous guidance, in connection with the open enrollment period for coverage in the 2026 benefit year, CMS will not take enforcement action against an issuer for failing to provide a product discontinuation notice with respect to individual market coverage at least 90 days prior to the discontinuation, as long as the issuer provides such notice consistent with the relevant timeframe applicable to renewal notices. The renewal notice timeframe for non-grandfathered, non-transitional plans[12] is before the first day of the next annual open enrollment period, and for grandfathered health plans and transitional plans is at least 60 days before the date of renewal.

States that are the primary enforcers of the federal guaranteed renewability requirements with respect to issuers are encouraged to adopt a similar approach to enforcement. CMS will not consider a state to have failed to substantially enforce the guaranteed renewability requirements because the state adopts such an approach.

This non-enforcement policy is limited to product discontinuations with respect to individual market coverage in connection with open enrollment for the 2026 benefit year. Issuers must continue to provide at least 90-days' notice of a product discontinuation with respect to group market coverage, and with respect to the discontinuation of an individual market product at other times of the year.

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[10] Sections 2703, 2712 (former), and 2742 of the PHS Act; 45 CFR 146.152, 147.106, and 148.122.

[11] For the most recent such announcement, see "Enforcement Safe Harbor for Individual Market Product Discontinuation Notices in Connection with the Open Enrollment Period for Coverage in the 2025 Benefit Year" (Jul. 17, 2024), available at https://www.cms.gov/files/document/2025-benefit-year-discontinuation-notices-safe-harbor.pdf

[12] For the requirements to qualify as a grandfathered health plan, see 45 CFR 147.140. For the requirements to qualify as a transitional plan, sometimes known as a grandmothered plan, as well as the most recent guidance with respect to such plans, see "Insurance Standards Bulletin Series – INFORMATION – Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years" (Mar. 23, 2022), available at https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.