September 29, 2025

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Submitted online: http://www.regulations.gov/

RE: CMS-10824 - Annual Notice of Change and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials

Dear Sir/Madam:

UnitedHealthcare (UHC) is responding to the Information Collection Request (ICR) for the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) for Applicable Integrated Plans (AIP) in States that Require Integrated Materials. The ICR was published by CMS in the Federal Register on July 31, 2025 (90 FR 36058).

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UHC is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

UHC recommends revising the content of Chapter 9 of the model EOC focusing on the member experience. As discussed below, we believe these changes will add additional clarity, expedite resolution of member's issues, and reduce or mitigate potential member confusion.

Chapter 9: What to Do If You Have a Problem or Complaint

Section B – Where to get help

- UHC suggests adding language in Section B1 (e.g., a new subtitle, "Help from your plan,") immediately prior to the paragraph entitled "Help from the state-specific name of the SHIP program," to encourage members to consider contacting their plan's customer service team prior to reaching out to the State Health Insurance Assistance Programs (SHIP) or filing a complaint with Medicare. This will help expedite resolutions to member concerns.
- UHC recommends adding the SHIP website and the hours of operation for the Medicare call center to the relevant sections in Section B1 to provide members with additional important contact information.

Section E – Coverage decisions and appeals

- The existing EOC model introductory section states: "You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered."

UHC believes this descriptive language provides clarity compared to the proposed language, "the process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care." The amended language, while substantially similar, is not as clear upon first reading. We recommend reverting to the existing language to ensure a better member experience, especially with the population served by Applicable Integrated Plans.

- In Section E3, UHC recommends maintaining the previous language regarding Appointment of Representative forms to note the timeframe members have to submit the form. The previous language stated, "If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal." Removing this language as proposed introduces uncertainty for the member regarding the timeframe for submitting the Appointment of Representative forms. Specifically, the revised language removes the reference to the 44 calendar days and thus creates potential member confusion and abrasion given the lack of clarity for when an appeal must be filed. We anticipate that this may be raised as an issue upon appeal to the Independent Review Organization (IRO) as not evident in the written materials.

Section F – Medical care

- In Section F3, UHC recommends adding a statement indicating that services do not need to be received to qualify for a fast appeal. We would suggest something to the effect of: "To start an appeal related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your representative must contact us." Additionally, UHC recommends adding a statement that the member, and/or the member's doctor, prescriber, or representative, will receive verbal confirmation in the event of an expedited appeal denial. This additional detail will help provide clarity for members and help them understand what to expect next in the process.

Section H – Asking us to cover a longer hospital stay

- In Section H1, UHC recommends adding clarification that the member may contact the Medicare call center 24 hours a day, 7 days a week. Ensuring members understand the call center is available 24 hours a day, 7 days a week in these sections will reinforce that members should not delay engaging in their care and coverage questions, especially related to hospital stays.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

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