



**Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)
The Center for Consumer Information and Insurance Oversight (CCIIO)**

**Marketplace Plan Management Group
Division of Issuer Compliance and Monitoring**

Plan Year 2017 FFE Notice Review Summary Report

December 8, 2017

Table of Contents

- 1. Executive Summary4**
- 2. Notice Reviews Background4**
- 3. Renewal and Discontinuation Notice Reviews Approach.....5**
- 4. Issuer Selection and Review Method.....5**
- 5. Notice Review Results.....5**
 - 5.1 Notice Format and Content 6
 - 5.1.1 CMS Review Methodology 6
 - 5.1.2 Results..... 6
 - 5.2 Timeliness 7
 - 5.2.1 CMS Review Methodology 7
 - 5.2.2 Results..... 7
 - 5.3 Notice Recipient..... 7
 - 5.3.1 CMS Review Methodology 8
 - 5.3.2 Results..... 8
 - 5.4 MOOP and Deductible 8
 - 5.4.1 CMS Review Methodology 8
 - 5.4.2 Results..... 9
 - 5.5 Benefit Cost Structure and Cost-Sharing Changes..... 9
 - 5.5.1 CMS Review Methodology 9
 - 5.5.2 Results..... 9
- 6. Appendix A: Additional Information on Notice Review Results.....11**
 - A.1 – Notice Timing, Format, and Content..... 11
 - A.2 – MOOP, Deductible, and Cost-Sharing for Other Benefits 12

List of Tables

Table 1: Notice Format and Content..... 7
Table 2: Notice Timeliness 7
Table 3: Notice Recipient 8
Table 4: Notice Deductible and MOOP 9
Table 5: Benefit Cost Structure and Cost-Sharing Changes 10

1. Executive Summary

In accordance with the Patient Protection and Affordable Care Act, as amended, and pursuant to 45 CFR 155.1010(a)(2) and 156.715, the Centers for Medicare & Medicaid Services (CMS), as administrator of the Federally-facilitated Exchanges (FFEs), conducts qualified health plan (QHP) Issuer oversight and compliance monitoring activities in the FFEs. Oversight and monitoring helps protect enrollees by ensuring Issuers maintain compliance with QHP certification standards and FFE requirements, identifying opportunities for improvement, and providing insight on where additional CMS guidance or direction is needed.

This report summarizes the results from reviews of renewal and discontinuation notices sent to enrollees in 2016 for the Plan Year 2017 (PY 2017) Open Enrollment Period (OEP). The sample of notices included in the review was derived from Issuers of individual market QHPs in FFE states where the states do not perform plan management functions. Specifically, this report provides insights on identified areas of noncompliance and potential noncompliance with CMS regulations and guidance. The data from this review and the subsequent report will not be used for any compliance actions. Overall, the 2017 FFE Notice Review shows significant improvement in Issuer notice review compliance with FFE standards and requirements.

2. Notice Reviews Background

Issuers in the Exchanges must adhere to 45 CFR 147.106 and 156.1255, which require them to send renewal and discontinuation notices, as appropriate, to their enrollees in a form and manner that complies with CMS guidance (see the September 2, 2016 bulletin).¹ This review focuses specifically on Issuer compliance with the standards described above.

CMS reviewed a sample of 1,063 renewal and discontinuation notices sent to enrollees in 2016 for the PY 2017 OEP. The sample was comprised of notices from 20 Issuers of individual market QHPs in FFE states where the states do not perform plan management functions. CMS reviewed the notices against requirements in the following five areas:

1. **Notice Format and Content:** Did the notice comply with content and formatting requirements?
2. **Timeliness:** Was the notice delivered to enrollees before the first day of PY 2017 OEP?
3. **Notice Recipient:** Was the recipient identified on the Renewal or Discontinuance Notice consistent with the information included with supporting documentation and attachments?
4. **Deductible and Maximum Out-of-Pocket (MOOP):** When a significant change in deductibles and/or MOOP was indicated, were the changes communicated to enrollees in the notice or via reference to supplemental materials, such as the Summary of Benefits and Coverage (SBC)?
5. **Benefit Value Changes:** Were significant benefit-level changes called out directly in the notice or by reference to supplemental materials?

¹ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-508.pdf>

The following assumption was made in the PY 2017 review: CSRs and APTCs, if included, are estimates based on PY 2016 coverage level and, therefore, are assumed correct.

3. Renewal and Discontinuation Notice Reviews Approach

CMS reviews QHP renewal and discontinuation notices for compliance with applicable requirements. Under 45 CFR 147.106 and 156.1255, Issuers renewing (including a renewal with modifications) or discontinuing coverage must include certain information in renewal and discontinuation notices to their enrollees.

To evaluate Issuer compliance with this bulletin, CMS reviewed renewal and discontinuation notices and supporting documentation that Issuers of individual market QHPs participating in the FFEs provided to enrollees. The scope of the review included the following five areas, which CMS determined to be the most critical in ensuring enrollees' access to care:

1. Notice Format and Content,
2. Timeliness,
3. Notice Recipient,
4. Deductible and MOOP Changes, and
5. Benefit Value Changes.²

This report provides an overview and results of the review that CMS performed on the notices sent to enrollees in 2016 regarding Open Enrollment for PY 2017, which is referred to in this report as the PY 2017 notice review.³

4. Issuer Selection and Review Method

CMS reviewed 1,063 notices sent by 20 Issuers of individual market QHPs in the FFEs. For the PY 2017 Notice Review, CMS identified a universe of QHP Issuers to select enrollment records where a plan was renewed or discontinued. CMS then categorized the enrollment records based on renewals or discontinuances of their QHPs from PY 2016 to PY 2017. Finally, CMS made a selection of plans using a random sample from the pool. This process ensured diverse representation of notices regarding QHPs that were renewed or discontinued.

Issuers submitted copies of renewal and discontinuation notices for specified enrollees, along with all supplemental documentation. Supplemental documentation included the SBC, or a letter regarding coverage changes other than those documented in the standard notice, that accompanied renewal and discontinuation notices provided to enrollees.

5. Notice Review Results

The following sections describe the results in each of the five areas that were the focus of this review (see Section 2).

² CMS reviewed six benefit areas: inpatient (hospital), emergency services, primary care, specialist visits, generic drugs, and preferred brand name drugs.

³ For purposes of this report, CMS defines PY 2017 as the period between January 1, 2017, and December 31, 2017.

5.1 Notice Format and Content

Issuers renewing coverage or discontinuing a product must provide written notice in a form and manner specified by CMS,⁴ unless the applicable state requires use of a different notice.⁵ In the September 2, 2016 bulletin, CMS requires that Issuers of individual market QHPs include the following information as part of the standard notice template for renewal or discontinuation notices, as applicable:

- A statement that the coverage is being discontinued;
- Information about premiums and APTC;
- Significant changes to coverage (including, but not limited to, changes in deductibles, cost sharing, metal level changes, covered benefits, eligibility, and provider network);⁶
- Information about other health coverage options;
- Contact information for the consumer to call with questions; and
- Other required information per 45 CFR 156.1255, including an explanation of the requirement to report changes to the FFEs in specific timeframes and channels, and changes to CSRs.

CMS also provided additional guidance in bulletins released on June 12, 2015, and August 25, 2015, about how to address APTC and CSR information in notices and reenrollment notifications, respectively.

5.1.1 CMS Review Methodology

CMS selected and reviewed 1,063 sample notices to evaluate whether Issuers notified enrollees of a QHP renewal or discontinuance using the Federal standard notices provided in the September 2, 2016 guidance.⁷ CMS reviewed whether Issuers included standard information in the required fields within the applicable standard notice, and whether the notices communicated required information to enrollees.

CMS found a notice noncompliant⁸ when information was either not contained in an appropriate field or added to the body of the notice outside of a field. Similarly, CMS considered a notice noncompliant if required fields were out of order or omitted.

5.1.2 Results

Of the notices reviewed, CMS found that 99.5% used the correct attachment and standard format for their plan status. Table 1 lists results related to this review area.

⁴ As detailed in the standard notices in the September 2, 2016 bulletin, available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-508.pdf>

⁵ No Issuers operating in a state with different notice requirements were included in this review.

⁶ These items may be described in supplemental materials enclosed with the notice.

⁷ The plan's status determines which Federal standard notice the Issuer should use, per the September 2, 2016 bulletin.

⁸ "Noncompliant" determinations are for the purposes of tabulating results for this report and not for compliance action.

Table 1: Notice Format and Content

Type	Results
Notice Format and Attachment Type	<ul style="list-style-type: none"> ▪ QHP Issuers provided the correct standard notice to the consumer nearly 100% of the time. ▪ Many of the communications in connection with PY 2017 included cover letters, the model notice, and attachments with description of plan benefits for PY 2017.
Notice Content	<ul style="list-style-type: none"> ▪ Generally, QHP Issuers are including all required fields as well as the name of the subscriber in the notice to the consumer. ▪ However, some Issuers did not include the appropriate language assistance tag-line for enrollees with limited English proficiency or who require TeleType/Telecommunications device for the deaf (TTY/TDD) assistance.⁹

5.2 Timeliness

Per the September 2, 2016 bulletin, Issuers must provide written notices to enrollees in a timely manner. For renewal notices, “timely” means Issuers provided notices to enrollees before the first day of the OEP.¹⁰

5.2.1 CMS Review Methodology

To test Issuer compliance with these requirements, CMS reviewed documentation submitted by Issuers which logged when the Issuers generated and mailed renewal and discontinuation notices for coverage offered through the FFEs. Where a log was not available, the date on the notice or cover letter was used as the basis for evaluation. CMS also reviewed notices to see whether the date in the notice matched the date listed in the documentation submitted by the Issuer. CMS considered renewal and discontinuation notices compliant if Issuers sent them before the 2017 OEP began on November 1, 2016.

5.2.2 Results

Results showed that Issuers sent notices in advance of the PY 2017 OEP 90% of the time. Table 2 lists results related to this review area.

Table 2: Notice Timeliness

Type	Results
Timeliness*	<ul style="list-style-type: none"> ▪ Some Issuers sent notices after the onset of the OEP.

*The results in the timeliness area for the PY 2017 notice review suggest a decrease in timely notification from the PY 2016 notice review (90% in PY 2017 and 96% in PY 2016).

5.3 Notice Recipient

An Issuer that discontinues a particular product must send a written discontinuation notice to each

⁹ For QHP Issuers subject to Section 1557 of the PPACA, notices sent on or after October 17, 2016, are required to include language assistance tag-lines in the top 15 non-English languages spoken in the applicable state or states. Guidance is available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-508.pdf>

¹⁰ CMS stated it would not take enforcement action against Issuers that sent discontinuation notices on the same timeframe as renewal notices (before the OEP), and encouraged state regulatory authorities to provide similar flexibility. See Insurance Standards Bulletin dated September 2, 2016 above.

individual and all participants and beneficiaries covered, and an Issuer that renews coverage must send a written renewal notice to the policyholder.¹¹

5.3.1 CMS Review Methodology

To evaluate compliance, CMS reviewed whether the notice included a recipient name and whether that name was clearly indicated and consistent with attachments and cover letters. This included all affected enrollees for discontinuance notices and for the policyholder for renewal notices.

5.3.2 Results

Almost all notices CMS sampled (>99%) included names that were consistent with attachments and cover letters. Table 3 lists results related to this review area.

Table 3: Notice Recipient

Type	Results
Validating Accuracy*	<ul style="list-style-type: none"> ▪ One Issuer provided a notice omitting consumer information entirely.

*The results in the notice recipient review were consistent with the PY 2016 notice review (>99% in PY 2017 and 99% in PY 2016).

5.4 MOOP and Deductible

Per the September 2, 2016 bulletin, Issuers must detail in the notice or supporting documents “significant changes to coverage, including, but not limited to, changes in deductibles, cost sharing, metal level changes, covered benefits, eligibility and provider network.” The list of information to be included in notices pursuant to the bulletin includes “significant changes to coverage, including...changes in...cost sharing.” CMS selected changes to MOOP as representative of changes in cost sharing for the purposes of this review. MOOP is a critical element for enrollees to make informed decisions about coverage options, as failure to include this element deprives enrollees of important information regarding the cost of coverage.

5.4.1 CMS Review Methodology

For PY 2017, CMS reviewed 954 notices of the 1,063 total notices where a change to the maximum out-of-pocket or deductible was indicated on the notice and evaluated whether notices of renewal or notices of discontinuation that automatically enrolled the consumer in a new plan included accurate information on the MOOP and deductibles for the 2017 plan. This differs slightly from the PY 2016 approach which was to only review notices identified by CMS as having been affected by a significant MOOP and deductible change: specifically, whether Issuers communicated the new MOOP or deductible amount, and whether the amount was accurate based on a comparison with CMS’s records. In PY 2017, CMS verified that the MOOP and deductible were included in the notice or in supplemental materials. CMS then compared the information for 954 notices to the SBC for the 2017 plan for accuracy.

¹¹ An important factor of evaluating compliance with this requirement is the assurance that Issuers sent the notice to the correct recipient (i.e., addressed the notice to the correct individual and only contained that individual’s information). While the regulations and guidance bulletins do not explicitly state this, CMS included it in the review as a “common sense” component.

5.4.2 Results

In the PY 2017 notice review, where the notice indicated a change in MOOP and/or deductible, CMS found Issuers clearly and accurately communicated a change in MOOP about 90% of the time, while Issuers communicated a correct change in deductible about 85% of the time. Table 4 lists results related to this review area.

Table 4: Notice Deductible and MOOP

Type	Results
Validating Accuracy*	<ul style="list-style-type: none"> ▪ Issuers did not communicate the correct MOOP or deductible amount to enrollees.
Communication	<ul style="list-style-type: none"> ▪ Issuers did not clearly communicate the change in MOOP or deductible for enrollees affected by MOOP or deductible changes.

*The results of correctly communicating a change in MOOP were significantly higher than the PY 2016 notice review results (90% in PY 2017 and 63% in PY 2016). The results of communicating a correct change in deductible were also significantly higher than the PY 2016 notice review (85% in PY 2017 and 63% in PY 2016).

5.5 Benefit Cost Structure and Cost-Sharing Changes

Per the September 2, 2016 bulletin, Issuers must notify enrollees of significant changes in coverage.¹²

5.5.1 CMS Review Methodology

To evaluate compliance with this requirement, CMS compared information included within each notice, as well as supplemental documents (such as the SBC), to determine if significant changes to specific benefit categories were indicated and whether Issuers were internally consistent when describing those significant changes in benefit cost structure and cost-sharing amounts. This review included the following six benefit categories: inpatient and hospital services, emergency services, primary care, specialist visits, generic drugs, and preferred brand name drugs.¹³

When a benefit cost-sharing amount was indicated, CMS checked the amount against its records, namely the SBC. The number and type of cost structure and cost-sharing amount changes varied across enrollees.

5.5.2 Results

The results of the PY 2017 notice review showed that Issuers accurately communicated significant cost structure changes 75.4% of the time (620 of 822 unique notices with one or more significant changes to one of the benefit categories) in renewal notices and discontinuance notices where enrollees were auto-enrolled in a new plan, when a significant change in benefit structure or cost-sharing amount was identified (see Appendix A, Table A.2 for range of results).

Table 5 lists results related to this review area.

¹² Per the September 2, 2016 bulletin, Issuers must detail in the notice or supporting documents “significant changes to coverage, including, but not limited to, changes in deductibles, cost sharing, metal level changes, covered benefits, eligibility, and provider network.”

¹³ CMS chose the six selected benefit areas as a reasonable representation of “significant changes to coverage” in the context of the September 2, 2016 bulletin, page 6 and to maintain similarity of review scope with previous PY reviews.

Table 5: Benefit Cost Structure and Cost-Sharing Changes

Type	Results
Validating Accuracy*	<ul style="list-style-type: none">▪ When a significant change in benefit value or cost-sharing was indicated, some Issuers did not provide enrollees with a cost-sharing amount that matched CMS' records.
Communication	<ul style="list-style-type: none">▪ Overall, Issuers did not always include or reference benefit-level or cost-sharing changes in the notice to the consumer.

*Overall, CMS found the notices it reviewed in the PY 2017 notice review included information on significant changes to benefit cost structure and cost-sharing amounts more often than the notices reviewed in the PY 2016 notice review (75.4% in PY 2017 versus 34% in PY 2016).

6. Appendix A: Additional Information on Notice Review Results***A.1 – Notice Timing, Format, and Content***

Criteria	Did Not Include/Does Not Meet Criteria	Did Include/Meets Criteria	Not Applicable* (N/A)	% Noncompliant	% Compliant	% N/A
Is letter dated prior to first day of open enrollment?	105	958	0	9.9%	90.1%	0.0%
Is applicable notice used?	5	1058	0	0.5%	99.5%	0.0%
Are required enrollee name(s) included?	1	1062	0	0.1%	99.9%	0.0%
Is Issuer contact information included?	0	1063	0	0.0%	100.0%	0.0%
Are language assistance tag-lines included (including TTY/TDD)?	156	907	0	14.7%	85.3%	0.0%
Does letter include APTC/CSR information?	16	1004	43	1.5%	94.4%	4.0%
Is new premium amount indicated?	1	1025	37	0.1%	99.9%	3.5%
Are all other variable fields completed?	103	960	0	9.7%	90.3%	0.0%
Total Records Examined						1063

*“Not Applicable” was used to indicate notices that suggested no information was to be reported (i.e., discontinuance with no re-enrollment), or no indication there was a change in information (e.g., APTC/CSR information).

A.2 – MOOP, Deductible, and Cost-Sharing for Other Benefits

	Did Not Include/Does Not Meet Criteria	Did Include/Meets Criteria	Change Indicated in Notice	% Did Not Include/Does Not Meet Criteria	% Did Include/Meets Criteria	% of Total Population
Medical Deductible	147	807	954	15.4%	84.6%	89.7%
Medical Maximum Out of Pocket	99	855	954	10.4%	89.6%	89.7%
Total Notifications with Significant Changes to Either MOOP or Deductible	159	795	954	16.6%	83.3%	89.7%
Primary Care Physician	115	629	744	15.5%	84.5%	69.9%
Specialist	114	645	759	15.5%	84.5%	70.0%
Emergency Room	120	559	679	15.0%	85.0%	71.4%
Inpatient Facility	189	501	690	17.7%	82.3%	63.9%
Generic Drugs	174	596	770	27.4%	72.6%	64.9%
Preferred Brand Drugs	162	649	811	22.6%	77.4%	72.4%
Number of Individual Notifications with Significant Benefit Changes	202	620	822	24.5%	75.4%	77.3%

*N/A: Type of notices (e.g., Renewal with no change or Discontinuance with no re-enrollment for 2017) precluded verification of PY 2017 information.