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

2018 Plan Year Notice Review Summary Report

April 25, 2019

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1. Executive Summary

In accordance with the Patient Protection and Affordable Care Act (PPACA), 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 discontinuance notices sent to enrollees in 2017 for the Plan Year 2018 (PY 2018) Open Enrollment Period (OEP). The sample of notices included in the review was derived from issuers of individual market QHPs in FFE states. 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 2018 FFE Notice Review identifies several areas where issuers can make improvements in complying with FFE notice review standards and requirements.

2. Notice Reviews

Issuers in the Exchanges must adhere to 45 CFR 147.106 and 156.1255, which require them to send renewal and discontinuance notices, as appropriate, to their enrollees in a form and manner that complies with CMS guidance (the guidance applicable to notices for the PY 2018 OEP was the September 2, 2016 bulletin).This review focuses specifically on Issuer compliance with the content and timeliness standards described in the September 2, 2016 Issuer Standards Bulletin[1]. CMS reviewed a sample of 834 renewal and discontinuance notices sent to enrollees in 2017 for the PY 2018 OEP. The sample was comprised of notices from 18 issuers of individual market QHPs and Stand-Alone Dental Plans (SADP) in FFE states. 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? Did the notice rely on other attached documents to communicate some required content?
2. **Timeliness:** Was the notice delivered to enrollees before the first day of PY 2018 OEP?
3. **Notice Recipient:** Was the recipient identified on the 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 MOOPs occurred, 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 Cost Structure and Cost-Sharing 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

3. Renewal and Discontinuance Notice Reviews Approach

CMS reviews QHP renewal and discontinuance 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 discontinuance notices to their enrollees.

To evaluate issuer compliance with §147.106 and §156.1255 as expanded in guidance provided by CCIIO in the September 2, 2016 Bulletin, CMS reviewed renewal and discontinuance 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 Cost Structure and Cost-Sharing Changes.[2]

CMS reviewed requirements explicitly stated in regulations, and CMS sub-regulatory guidance.

This report provides an overview and results of the review that CMS performed on the notices sent to enrollees in 2017 for the Open Enrollment period for 2018 coverage, which is referred to in this report as the PY 2018 notice review.[3]

4. Issuer Selection and Review Method

CMS reviewed renewal and discontinuance notices for 834[4] subscribers representing 18 issuers of individual market QHPs in the FFEs. CMS identified and categorized issuers for the PY 2018 notice review based on renewals or discontinuances of their QHPs from PY 2017 to PY 2018. The sample of issuers is based on the subset of issuers that had plans renewed and/or discontinued. From that subset of issuers, CMS selected issuers that were deemed to be at a greater risk of potential non-compliance based on a review of certification data and post-certification assessment (PCA) data. Finally, CMS selected plans using a random sample from the pool-stratified random sampling. Once the population of renewal notices was identified, a sub-sample was selected, including 66 renewal notices where significant changes to the maximum out-of-pocket, deductible, or other benefit cost structure and cost-sharing changes from PY 2017 to PY 2018 were identified. This process ensured diverse representation of notices regarding QHPs that were renewed or discontinued.

Issuers submitted copies of renewal and/or discontinuance notices for specified enrollees, along with all

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[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 2018 as the period between January 1, 2018, and December 31, 2018.

[4] A sample of 900 subscribers representing 18 issuers were selected initially for review. Of the 900 renewal or discontinuance notices requested, 66 notices were not provided due to voluntary termination of coverage or termination of coverage due to non-payment of premium prior to the first day of the PY2018 annual open enrollment period. These samples were therefore excluded.

supplemental documentation. Appropriate supplemental documentation includes a Statement of Benefits and Coverage (SBC) or other documentation describing coverage changes other than those documented in the standard notice, which accompanied the renewal and/or discontinuance notices provided to enrollees.

5. Notice Review Results

The following sections describe CMS' findings and observations in each of the five areas (see Section 3.) for issuers.

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,[5] unless the applicable state requires use of a different notice.[6] CMS continues to consider the information listed in the September 2, 2014 Bulletin[7] to be essential content to be included as part of the standard notice template for renewal or discontinuance notices, as applicable:

- A statement that the coverage is being discontinued;
- Information about premiums and APTC in the next policy year;
- Significant changes to coverage (including, but not limited to, changes in deductibles, cost sharing, metal-level changes, covered services, eligibility, plan formulary, and provider network);[8]
- 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 reviewed 834 notices to evaluate whether issuers notified enrollees of a QHP renewal or discontinuance prior to the first day of open enrollment using the updated Federal standard notices provided in the September 2, 2016 Issuer Standard Bulletin.[9] 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.

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[5] 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.
[6] No issuers operating in a state with different notice requirements were included in this review.
[7] Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.pdf.
[8] These items may be described in supplemental materials enclosed with the notice.
[9] The plan's status determines which Federal standard notice the issuer should use, per the September 2, 2016 Bulletin.

CMS found a notice noncompliant[10] 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 834 discontinuance and renewal notices reviewed, CMS found 71.6% used the correct attachment and standard format including the required elements for their plan status. See **Table 1** for a description of the findings and observations identified.

Table 1. Notice Format and Content Findings and Observations

Type	Results
Notice Format and Attachment Type	▪ QHP issuers provided the correct standard notice more consistently for renewed plans than for discontinued plans. ▪ Many of the communications in connection with PY 2018 included cover letters, the model notice, and attachments with a description of plan benefits for PY 2018. ▪ QHP issuers may be using older model notices or model notices intended for plan and product renewals for discontinued plans.
Notice Content	▪ Generally, QHP issuers are including a fully completed notice attachment as well as the name of the subscriber in the notice to the consumer. ▪ Some issuers, however, did not include the appropriate language assistance tagline for enrollees with limited English proficiency or those who require TeleType/Telecommunications device for the deaf (TTY/TDD) assistance.[11] ▪ A small number of QHP issuers are not including or are incorrectly including key content such as APTC amount, metal level, or premium amounts.

5.2 Timeliness

Per the September 2, 2016, Issuer Standards 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.[12]

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 discontinuance notices for coverage

[10] “Noncompliant” determinations are for the purposes of tabulating results for this report and not for taking any compliance action.
[11] For QHP issuers subject to Section 1557 of the PPACA, notices sent on or after October 17, 2016, are required to include language assistance taglines 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.
[12] CMS stated it would not take enforcement action against issuers that sent discontinuance notices in the same timeframe as renewal notices (before the OEP) and encouraged state regulatory authorities to provide similar flexibility. See the September 2, 2016 Bulletin.

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 discontinuance notices compliant if issuers sent them before the PY 2018 OEP began on November 1, 2017.

5.2.2 Results

Results showed that issuers sent notices in advance of the PY 2018 OEP 81.9% of the time. See **Table 2** for a description of the findings and observations identified.

Table 2: Notice Timeliness Findings and Observations

Type	Results
Timeliness	▪ QHP and SADP issuers are sending required notices prior to the beginning of the OEP more consistently for renewals than for discontinuances. ▪ Some issuers sent notices up to 20 days after the first day of the OEP.

5.3 Notice Recipient

An issuer that discontinues a particular product must send a written discontinuance notice to each individual and all participants and beneficiaries covered under the coverage, and an issuer that renews coverage must send a written renewal notice to the policy holder.[13]

5.3.1 CMS Review Methodology

To evaluate compliance, CMS reviewed whether the notice included a recipient, that the name was clearly indicated and consistent with attachments and cover letters, and that the name was consistent with the associated enrollment file provided by CMS.

5.3.2 Results

The majority of notices reviewed (98.5%) included recipient names on the notice and attachments that were consistent with information included in the enrollment file. See **Table 3** for a description of the findings and observations identified.

Table 3: Notice Recipient Findings and Observations

Type	Results
Validating Accuracy	▪ One issuer provided a notice omitting consumer information entirely.

5.4 MOOP and Deductible

To provide notice in the form and manner that complies with CMS guidance, issuers must describe in the notice or supporting documents significant changes to coverage, including, but not limited to,

[13] 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.

changes in deductibles, cost sharing, metal level, coveredservices, eligibility, plan formulary and provider network. CMS selected MOOP and Deductible as critical elements for consumers to make informed decisions about coverage options, as failure to include this element deprives consumers of important information regarding the cost of coverage.

5.4.1 CMS Review Methodology

To evaluate compliance, CMS reviewed notices affected by a change to the MOOP or deductible. Specifically, CMS evaluated whether issuers communicated the new MOOP or deductible amount, and whether the amount was accurate based on a comparison with CMS' records.

5.4.2 Results

In the PY 2018 notice review, CMS found issuers clearly communicated a change in the deductible about 56.1% of the time, while issuers communicated a correct change 59% of the time for changes to the MOOP. See **Table 4** for a description of the findings and observations identified.

Table 4: Notice Deductible and MOOP Findings and Observations

Type	Results
Validating Accuracy	▪ QHP issuers did not communicate the correct MOOP or deductible amount or did not include the MOOP or Deductible in its communications to enrollees at similar rates .
Communication	▪ QHP issuers did not clearly communicate the change in MOOP or deductible for enrollees affected by MOOP or deductible changes.

5.5 Benefit Cost Structure and Cost-Sharing Changes

To provide notice in the form and manner that complies with CMS guidance, issuers must describe in the notice or supporting documents significant changes to coverage, including, but not limited to, changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. CMS selected significant changes to benefit cost structure and cost-sharing.

5.5.1 CMS Review Methodology

To evaluate compliance with this requirement, CMS compared information included within each notice and any supplemental documents (such as the SBC) provided by the QHP Issuer to determine if significant changes to specific benefit costs were communicated. Specifically, the review included an examination of the following six benefit categories: inpatient hospital services, emergency services, primary care, specialist visits, generic drugs, and preferred brand name drugs.[14] When a benefit cost structure or cost-sharing amount was included, CMS checked the amount against its records. The number and type of benefit cost structure and cost-sharing amount changes varied across enrollees.

[14] 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 5) and to maintain similarity of review scope with previous PY reviews.

5.5.2 Results

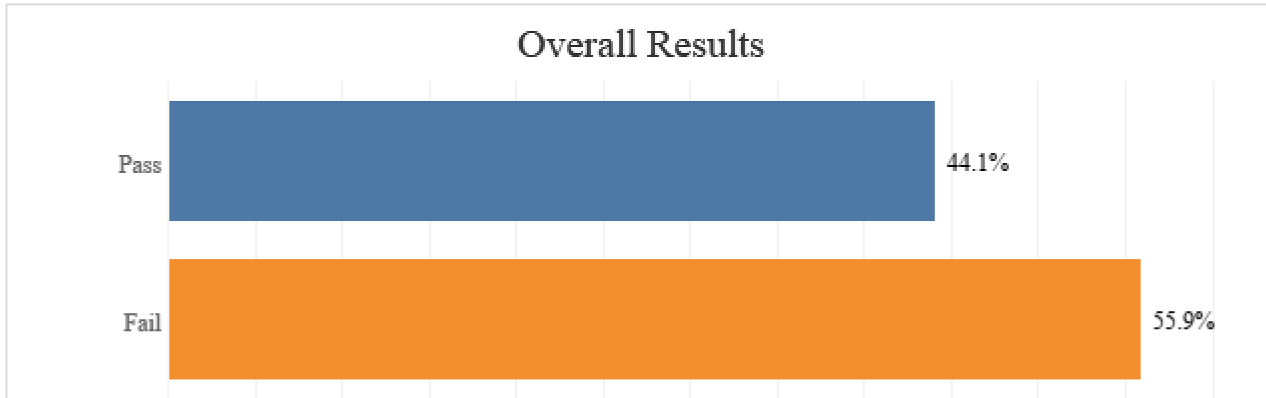
Overall, CMS found the notices it reviewed in the PY 2018 notice review included information on significant changes to benefit cost structure and cost-sharing amounts 85% of the time. See **Table 5** for a description of the findings and observations identified.

Table 5: Benefit Cost Structure and Cost-Sharing Changes Findings and Observations

Type	Results
Validating Accuracy	▪ When a change in benefit cost structure or cost-sharing was suggested, some issuers did not provide enrollees with a benefit level that matched CMS records.
Communication	▪ Overall, issuers did not always include or reference benefit-level changes in the notice to the consumer.

6. Appendix A: Additional Information on Notice Review Results

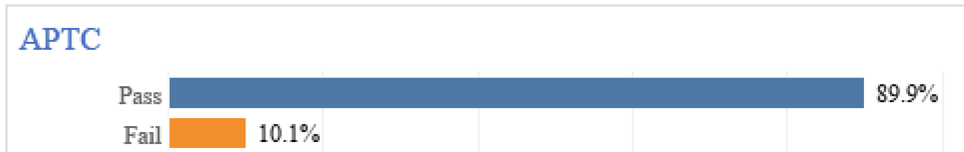
Summary of Overall Review Results



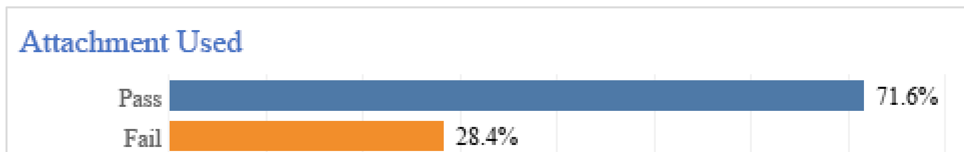
	Number of Records	%
Pass	368	44.1%
Fail	466	55.9%
Total	**834**	**100.0%**

Sample ID	Pass	Fail	Total	Pass %	Fail %
1		48	48		100.0%
2		50	50		100.0%
3	48	1	49	98.0%	2.0%
4	45	5	50	90.0%	10.0%
5	44	5	49	89.8%	10.2%
6	37	13	50	74.0%	26.0%
7		48	48		100.0%
8	17	8	25	68.0%	32.0%
9	23	26	49	46.9%	53.1%
10		50	50		100.0%
11		49	49		100.0%
12	49	1	50	98.0%	2.0%
13	30	8	38	78.9%	21.1%
14	2	34	36	5.6%	94.4%
15		48	48		100.0%
16	1	47	48	2.1%	97.9%
17	33	15	48	68.8%	31.3%
18	39	10	49	79.6%	20.4%
Total	**368**	**466**	**834**	**44.1%**	**55.9%**

6.1 Summary of Notice Format and Content Review Results

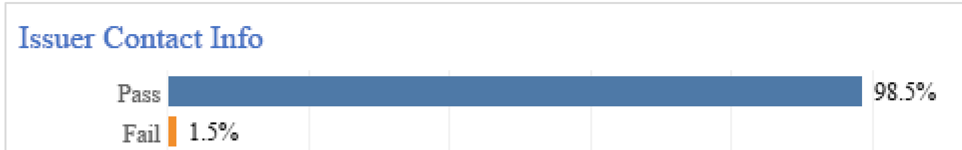


APTC	Number of Records	%
Pass	551	89.9%
Fail	62	10.1%
Total	**613**	**100.0%**



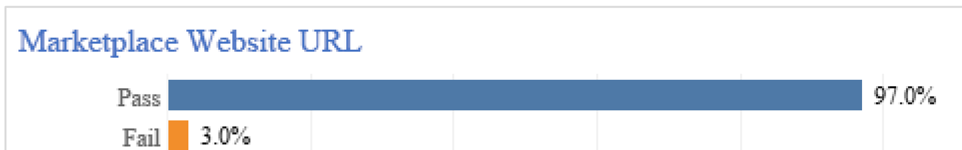
Attachment Used	Number of Records	%
Pass	597	71.6%
Fail	237	28.4%
Total	**834**	**100.0%**

Conform To Attachment Template	Number of Records	%
Pass	61	92.4%
Fail	5	7.6%
Total	**66**	**100.0%**

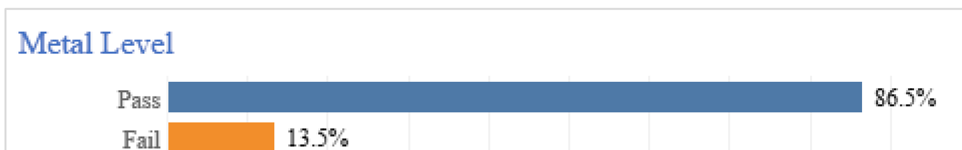


Issuer Contact Info	Number of Records	%
Pass	65	98.5%
Fail	1	1.5%
Total	**66**	**100.0%**

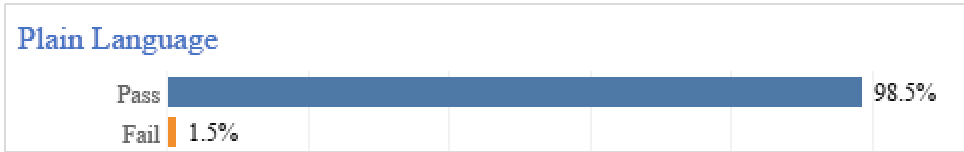
Language Accessibility Tagline	Number of Records	%
Pass	785	94.1%
Fail	49	5.9%
Total	**834**	**100.0%**



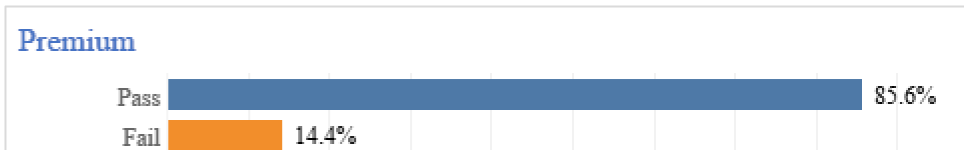
Marketplace Website URL	Number of Records	%
Pass	64	97.0%
Fail	2	3.0%
Total	**66**	**100.0%**



Metal Level	Number of Records	%
Pass	530	86.5%
Fail	83	13.5%
Total	**613**	**100.0%**

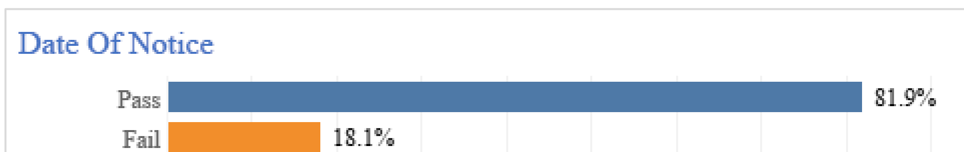


Plain Language	Number of Records	%
Pass	65	98.5%
Fail	1	1.5%
Total	**66**	**100.0%**



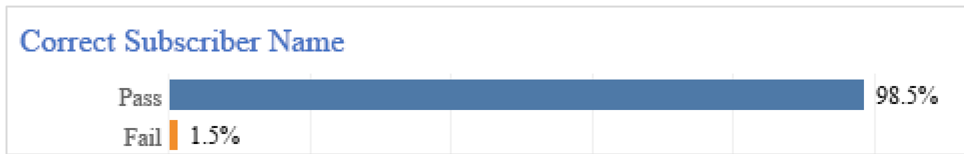
Premium	Number of Records	%
Pass	525	85.6%
Fail	88	14.4%
Total	**613**	**100.0%**

6.2 Summary of Timeliness Review Results



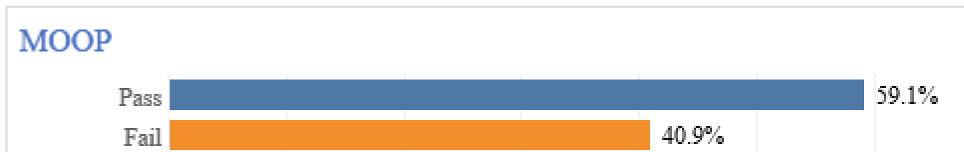
Date of Notice	Number of Records	%
Pass	683	81.9%
Fail	151	18.1%
Total	**834**	**100.0%**

6.3 Summary of Notice Recipient Review Results

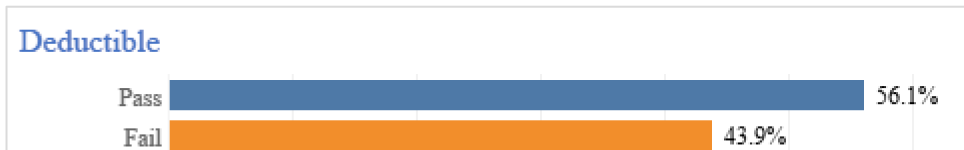


Correct Subscriber Name	Number of Records	%
Pass	65	98.5%
Fail	1	1.5%
Total	**66**	**100.0%**

6.4 Summary of MOOP and Deductible Review Results



MOOP	Number of Records	%
Pass	39	59.1
Fail	27	40.9%
Total	**66**	**100.0%**

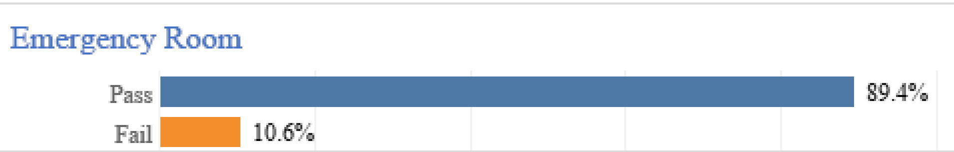


Deductible	Number of Records	%
Pass	37	56.1%
Fail	29	43.9%
Total	**66**	**100.0%**

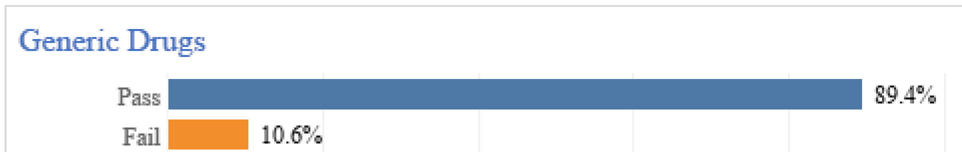
6.5 Benefit Cost Structure and Cost-Sharing Results

	Number of Records	%
Pass	10	15.2%
Fail	56	84.8%
Total	**66**	**100.0%**

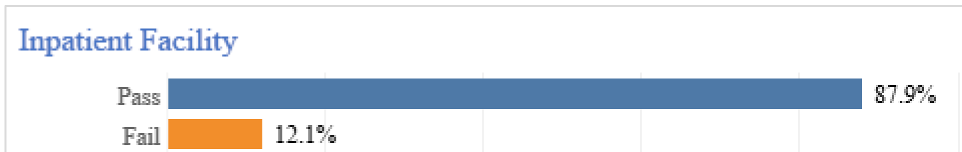
Sample ID	Pass	Fail	Total	Pass %	Fail %
1		9	9		100.0%
2					
3	3		3	100.0%	
4	1		1	100.0%	
5	1	6	7	14.3%	85.7%
6		6	6		100.0%
7					
8	2	6	8	25.0%	75.0%
9	1	5	6	16.7%	83.3%
10		7	7		100.0%
11		3	3		100.0%
12	1		1	100.0%	
13		3	3		100.0%
14		4	4		100.0%
15		2	2		100.0%
16		1	1		100.0%
17	1		1	100.0%	
18		4	4		100.0%
Total	10	56	66	15.2%	84.8%



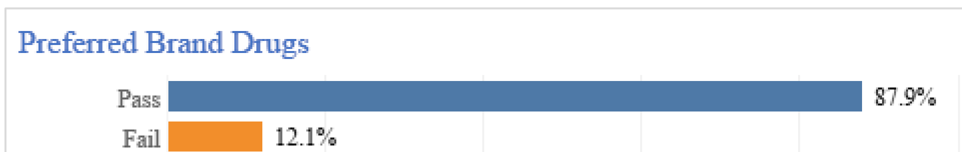
Emergency Room	Number of Records	%
Pass	59	89.4%
Fail	7	10.6%
Total	**66**	**100.0%**



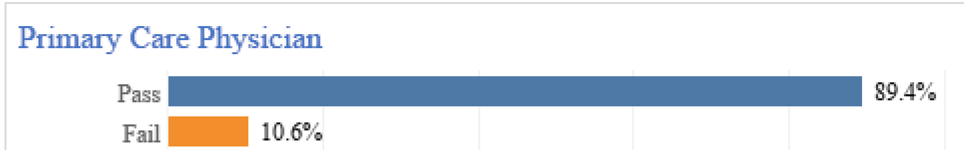
Generic Drugs	Number of Records	%
Pass	59	89.4%
Fail	7	10.6%
Total	**66**	**100.0%**



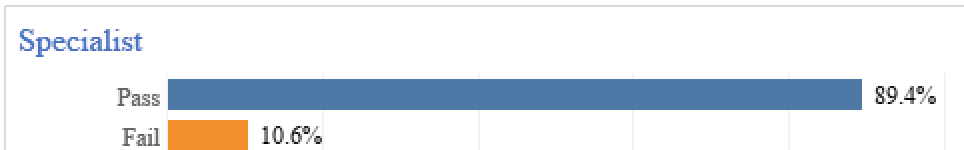
Inpatient Facility	Number of Records	%
Pass	58	87.9%
Fail	8	12.1%
Total	**66**	**100.0%**



Preferred Brand Drugs	Number of Records	%
Pass	58	87.9%
Fail	8	12.1%
Total	**66**	**100.0%**



Primary Care Physician	Number of Records	%
Pass	59	89.4%
Fail	7	10.6%
Total	**66**	**100.0%**



Specialist	Number of Records	%
Pass	59	89.4%
Fail	7	10.6%
Total	**66**	**100.0%**