Centers for Medicare & Medicaid Services (CMS)
The Center for Consumer Information and Insurance Oversight (CCIIO)

2017 Plan Year
Federally-Facilitated Exchange
Issuer Compliance Review Summary Report

February 8, 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) conducts Qualified Health Plan (QHP) issuer oversight and compliance monitoring activities in Federally-Facilitated Exchanges (FFEs) including those in states performing plan management functions. Oversight and monitoring activities help protect consumers by ensuring issuers are compliant with FFE standards. FFE compliance reviews also help issuers identify opportunities for improvement and provide insight to CMS on areas where additional guidance may be helpful.

This report summarizes the results from FFE compliance review activities related to plans certified for Plan Year (PY) 2017.[1] By sharing this report, CMS can provide insights on identified areas of non-compliance in 2017 and help issuers ensure their processes, procedures, and activities comply with CMS regulations and guidance.

Per 45 CFR § 155.1010(a)(2) and 156.715, CMS may conduct compliance reviews of issuers offering QHPs, including stand-alone dental plans (SADPs), in the FFEs to ensure ongoing compliance with QHP certification standards and FFE requirements. CMS selected 15 issuer identifications (IDs) from 9 FFE states[2] for compliance reviews of plans certified for PY 2017. These compliance reviews focused on issuer processes and operational testing related to the following areas: prescription drug benefits, QHP issuer participation standards, transparency in coverage reporting, rate and benefits information, marketing and benefit design, network adequacy and Essential Community Providers (ECPs), meaningful access to health plan information, enrollment periods for qualified individuals, enrollment processes for qualified individuals, termination of coverage for qualified individuals, issuer oversight of delegated and downstream entities including affiliated agents and brokers, health insurance casework system (HICS), rating variations, and compliance plans.

The results from compliance reviews are categorized as “findings” or “observations.” “Findings” result from discovery of evidence of non-compliance, in addition to cases of confirmed or admitted non-compliance. Observations result from the discovery of practices or procedures which represent a compliance risk but there was no evidence of non-compliance with Exchange requirements.

The reviews further divide results by methodology. Process findings or observations were primarily issues identified with an issuer’s underlying process to complete a required activity. Performance findings or observations were primarily included when an issuer’s process included all of the required elements, but operational testing indicated that those elements were not followed consistently. In some cases, a combination of process and performance findings or observations were discovered due to an issuer having problems with both its process and performance of a required activity.

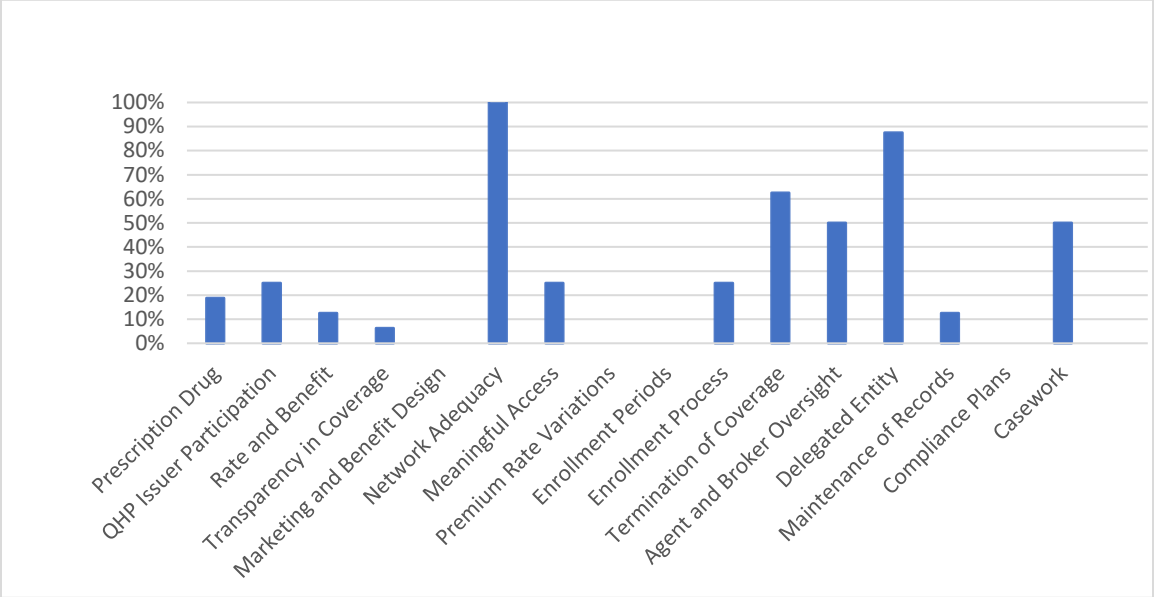
[1] For the purposes of this report, CMS defines Plan Year 2017 as the period between January 1, 2017 and December 31, 2017.
[2] The nine FFE states were AK, AL, AZ, FL, GA, NJ, TX, WI, and WY.

The following review areas were the most likely to produce findings and observations during the compliance review process:

- Network Adequacy: CMS identified issues regarding network adequacy including: issuers did not offer contracts to ECPs and Indian health care providers as required by 45 CFR § 156.235(a)(2)(ii); provider directories did not identify whether providers were accepting new patients; and certain data elements in provider directories were not up-to-date and accurate as required by 45 CFR § 156.230(b).
- HICS Casework: CMS identified issues with the timely resolution, documentation, and complainant notification of HICS casework as required by 45 CFR § 156.1010.
- Termination Notices for Qualified Individuals: CMS identified issues with the timeliness or accuracy of notices sent to enrollees, specifically termination notices were not sent timely or did not include the termination effective date or the reason for termination as required by 45 CFR § 156.270(b).
- Meaningful Access: CMS identified some issuer notices, websites and/or published material that did not include all of the language on obtaining coverage or access to medical services through the QHP as required by 45 CFR § 156.250.
- Agent and Broker Oversight: CMS identified issues with inadequate monitoring of affiliated agents and brokers (i.e., issuers did not consistently confirm whether their respective affiliated agents and brokers completed the required FFE registration and training before assisting Exchange consumers) as required by 45 CFR §156.340(a)(3).
- Downstream and Delegated Entities: CMS identified issues with some issuers' downstream and delegated entity contracts which did not include the language required by 45 CFR § 156.340(b).
- Enrollment Process for Qualified Individuals (Privacy and Security Policies): CMS identified issues with issuers' privacy and security policies or, in some cases, specific incidents where the issuers did not comply with or were not consistently aware of requirements to report any breach or security incidents to the CMS IT help desk either by email or phone calls within the time frames required under the FFE privacy and security policies pursuant to 45 CFR §§ 155.260 and 156.265(b)(3)(iii).

CMS considers it a best practice for issuers to review the results summarized in this report and use this information to identify opportunities for improvement in their own policies, procedures, and processes. CMS expects issuers to be familiar with FFE standards and processes and to have mechanisms in place to self-monitor compliance. Figure 1 displays the percentage of reviewed issuers with findings and observations in each review area; issuers may have had multiple results in an area.

Figure 1: Percentage of Issuers Reviewed with Findings and Observations by Area[3]



2. COMPLIANCE REVIEW PROCESS

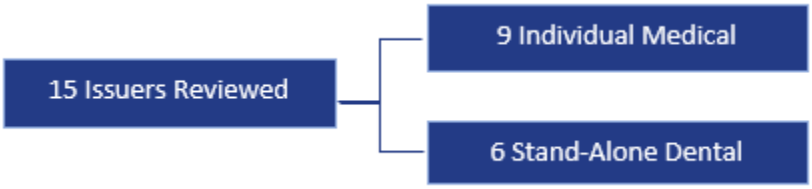
Under 45 CFR § 155.1010(a)(2) and § 156.715, CMS has the authority to perform compliance reviews of issuers offering QHPs, including SADPs, in the FFEs to ensure ongoing compliance with requirements for QHP certification under 45 CFR Part 156 and other FFE standards. FFE compliance reviews may help issuers identify opportunities for improvement in meeting regulatory requirements and assist CMS in determining where additional guidance may be helpful. This section provides an overview of the compliance review process. A visual representation of the compliance review steps is depicted in Figure 2. CMS also released guidance in the form of the *Key Priorities for FFE Compliance Reviews for the 2017 Benefit Year,* which set forth a list of regulatory standards that CMS planned to include in the PY 2017 compliance reviews. This document is available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table-KeyPriorities_2017Final.pdf.

Figure 2: The FFE Compliance Review Process

[3] Statistics represented have been determined by the number of findings or observations attributed to a particular review area. Scoring may represent multiple findings attributed to the same area, as seen under Network Adequacy which includes both Provider Directory and ECP contracting findings or observations. Issuers may have had more than one finding or observation by review area.

CMS selects issuers for compliance reviews based on performance data and ongoing monitoring activities. For PY 2017, CMS conducted compliance reviews of 15 issuers**.** Beginning in July 2017, CMS issued notifications to the selected issuers and conducted kick-off calls to discuss each issuer's selection and the compliance review process, and to inform the issuer of any documentation needed prior to the start the reviews. After receiving and reviewing the requested documentation, CMS conducted interviews with each issuer's staff about its FFE operations. Figure 3 shows a breakdown of the issuer characteristics for the PY 2017 compliance reviews.

Figure 3: Issuer Characteristics for PY 2017 Compliance Reviews



The PY 2017 compliance reviews consisted of 3 onsite reviews (encompassing 4 QHPs) and 11 desk reviews.[4] During each review, CMS: 1) reviewed issuers' policies, procedures, and processes for all review areas within the scope of the review (as applicable), and 2) performed testing for 13 of the 16 review areas to assess compliance with FFE regulations.

The next section details the results of the PY 2017 compliance reviews by review area. The PY 2017 compliance reviews focused more on issuers' processes and performance, and less on their written policies and procedures than prior years. Written policies and procedures were requested and reviewed as an aid for determining whether an issuer's processes and performance complied with FFE requirements and to provide a basis for any recommendations.

3. COMPLIANCE REVIEW RESULTS

Findings and observations contained in this report align with the 16 review areas noted in the Executive Summary and associated regulatory standards. Tables 1-16 present findings and observations for each of the 16 review areas. Findings result from discovery of evidence of non-compliance, in addition to cases of confirmed or admitted non-compliance. Observations result from discovery of evidence of practices or procedures which represent a compliance risk, but there was no evidence of non-compliance, in addition to identification of areas for improvement .

CMS classified findings and observations[5] based on the type of review methodology[6] employed:

[4] CMS conducted onsite reviews at an issuer's facility when a parent company had centralized operations for multiple issuers in one location. For desk reviews, CMS used telephone interviews, and email to collect the necessary information and documents for review.
[5] Review areas may contain findings, observations, or both, depending on testing results.
[6] Information about the CMS Review Methodologies is a high-level summary of the review processes completed for each area under review. It is not expected that this information provides sufficient guidance to complete a similar review and necessarily arrive at the same conclusion.

- **Process Review:** This included review of issuers' written processes and procedures for review areas within the scope of the PY 2017 compliance reviews. Throughout the reviews, CMS requested and examined applicable policies and procedures established and provided by the issuers. This was completed primarily for informational purposes as most regulations do not require a written policy or procedure.
- **Performance Testing:** This included testing to assess issuers' compliance with FFE regulations for review areas within the scope of the PY 2017 compliance review. CMS completed testing using either 100% of available data (e.g., contracts, cases, notices) or a random sample of data. The decision of which sampling methodology to use was based on the test being performed.

Results by Review Area

This section describes the standards and requirements for each of the 16 review areas, the methodology CMS used to review issuer compliance, any associated findings and observations, and suggested best practices for review areas that produced findings or observations.

3.1 Prescription Drug Formulary

Pursuant to 45 CFR § 156.122, an issuer's health plan provides an essential health benefits (EHB) package with respect to prescription drugs if it, among other things:

- Covers at least the greater of one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan;
- Submits its formulary drug list to the FFE, the State, or the Office of Personnel Management (OPM);
- Uses a pharmacy and therapeutics committee that meets specific membership standards;
- Has procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by its health plan; and
- Provides an up-to-date, accurate, and complete listing of all covered drugs on its formulary list in a manner that is easily accessible on its website.

3.1.1 *CMS Review Methodology*

CMS reviewed prescription drug formularies available on the issuers' websites against those submitted as part of the PY 2017 QHP application process to determine whether there were significant changes to the formularies since certification, which may be prohibited by non-discrimination requirements specified at 45 CFR §§ 156.125 and 156.225(b). In addition, CMS reviewed the issuer's drug formularies to determine if the number of specific drugs available met the minimum threshold requirements of 45 CFR § 156.122(a)(1) across a broad range of therapeutic classes and recommended drug treatment regimens. CMS also reviewed the issuers' exception request process to determine if the evaluation and notification process is completed in a manner consistent with the requirements of 45 CFR § 156.122(c).

3.1.2 *Results*

Table 1 lists findings or observations related to this review area.

Table 1: Prescription Drug Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Drug exception request determinations and notifications were not completed or provided to the patient or designee within required timeframes.

3.1.3 *Best Practices*

- Regularly review formularies, especially when they are managed by a third party, to ensure any mid-year changes conform to applicable regulations.
- Regularly review published formularies to ensure they include a current and complete list of all covered drugs, including any tier structure that has been adopted, and any restrictions to obtaining a drug.
- Regularly review implementation of the drug exception request process to ensure requests are being evaluated, decisions are made, and notifications are sent as required and within the applicable timeframes.

3.2 QHP Issuer Participation General Standards

Pursuant to 45 CFR § 156.200, Exchange participation standards require QHP issuers to, among other things:

- Have each QHP certified by the Exchange in which it is being offered;
- Comply with Exchange processes, procedures, and requirements under Title 45, Part 155, Subpart K and, in the small group market, 45 CFR § 155.705;
- Offer at least one gold and one silver plan through the Exchange;
- Not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and
- Provide the same agent and broker compensation for similar coverage offered inside and outside the Exchanges.

3.2.1 *CMS Review Methodology*

CMS reviewed written non-discrimination policies to ensure that policies were in place and available to employees and that the policies included all classes identified under the regulation. CMS also reviewed agent and broker compensation policies and practices, subscriber agreements, and lists of the QHPs (by type) offered under the participating issuer IDs.

3.2.2 *Results*

Table 2 lists findings or observations related to this review area.

Table 2: QHP Issuer Participation General Standards Findings or Observations

Review Methodology	Findings or Observations
Process Testing	▪ Issuer's written policy or process documents did not include all classes identified in the regulation, such as race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

3.2.3 *Best Practices*

- Review written policies and procedures to ensure they are consistent with regulatory requirements related to non-discrimination.

3.3 Rate and Benefit Information

Pursuant to 45 CFR § 156.210(c), a QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase and prominently post the justification on its website.

3.3.1 *CMS Review Methodology*

CMS reviewed issuers' websites to determine if applicable rate increase justifications, or links to them, were available on their websites.

3.3.2 *Results*

Table 3 lists findings or observations related to this review area.

Table 3: Rates and Benefits Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer did not post the justification for a premium rate increase on its website.

3.3.3 *Best Practices*

- Establish an annual process to ensure the rate increase justifications are posted to issuer websites consistent with Exchange regulations.

3.4 Transparency in Coverage

Pursuant to 45 CFR § 156.220, QHP issuers must provide specific information to the Exchange, the Department of Health and Human Services (HHS), and the State insurance commissioner. This information must also be made available to the general public, in plain language, through a website or other means for individuals without access to the internet.

3.4.1 *CMS Review Methodology*

CMS reviewed issuer websites to determine if the issuer provided links to the required claims payment policy and other required information, URLs, or to a repository of the required information either on a single page or within multiple webpages that may be accessible from a landing page.

3.4.2 *Results*

Table 4 lists findings or observations related to this review area.

Table 4: Transparency in Coverage Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer did not maintain an active URL that contained all of the required transparency in coverage information.

3.4.3 *Best Practices*

- Establish an annual process to ensure active links are posted to the issuer website containing the required information.

3.5 Marketing and Benefit Design

Pursuant to 45 CFR § 156.225(b), QHP issuers may not employ marketing practices or benefit designs that have the effect of discouraging enrollment of individuals with significant health needs.

3.5.1 *CMS Review Methodology*

CMS reviewed FFE issuers' processes related to marketing and benefit design to determine whether they included procedures intended to prevent discriminatory practices in the development of plan benefits, including coverage standards and limitations.

3.5.2 *Results*

Table 5 lists findings or observations related to this review area.

Table 5: Marketing and Benefit Design Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ No findings or observations were identified in this review area.

3.5.3 *Best Practices*

- N/A

3.6 Network Adequacy

Pursuant to 45 CFR § 156.230(a)(2) and (b), issuers with QHPs that use provider networks are required to maintain a sufficient provider network by:

- Ensuring all services, including access to mental health and substance abuse services, are accessible without unreasonable delay and are consistent with the network adequacy provisions of Section 2702(c) of the Public Health Service Act;
- Making an accurate and up-to-date provider directory available to the Exchange for publication online and providing a hard copy to potential enrollees upon request; and
- Identifying which providers are not accepting new patients in their provider directories.

Pursuant to 45 CFR § 156.235(a), QHP issuer networks must also have a sufficient number and geographic distribution of ECPs. An ECP is a provider that serves predominantly low-income, medically underserved individuals. QHP issuers must satisfy the following criteria, among other requirements:

- Offer contracts in good faith to all available Indian health care providers in the service area; and
- Offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP in that category is available.

3.6.1 *CMS Review Methodology*

CMS evaluated the issuer's provider directory to determine if 1) a provider directory is available to enrollees both online and in hard copy upon request, 2) online and printed directories clearly identify providers that are not accepting new patients, and 3) demographic and other required information is included in the provider directory.

CMS accessed the issuers' online provider directories and selected a sample of providers from different specialty groups. Each provider office in the sample was contacted to confirm that the demographic information published in the directory was up-to-date, accurate, and complete. The information gathered during this contact was documented and compared to the submitted provider directory record to confirm that the location, telephone number, specialty, medical group, institutional affiliations, and reported status of the provider as not accepting new patients were correct. In cases where the issuer also created a stand-alone hard copy directory, CMS determined if it was consistent with the online directory.

CMS' testing in this review area also included a comparison of the issuers' ECP lists against the *HHS 2017 Non-Exhaustive List of ECP*s to identify if there were any counties and/or specialties within the issuers' services areas which did not meet the FFE requirements for ECPs. In those counties where issuers did not meet ECP requirements, CMS requested documentation that the issuers had extended a good-faith offer to contract to all Indian health care providers within the issuers' service areas and at least one ECP provider in each category in each county in the issuers' service areas.

3.6.2 *Results*

Table 6 lists findings or observations related to this review area.

Table 6: Network Adequacy Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Provider directories did not indicate whether providers were accepting new patients, and/or included incorrect or out-of-date information (e.g., some sampled providers were no longer in practice and/or had incorrect contact information). ▪ Issuer's ECP list did not meet all ECP contract-offer requirements (e.g., some QHP issuers did not offer contracts to one or more Indian health care providers in their service area or could not provide documentation proving such contract offers were made).

3.6.1 *Best Practices*

- Regularly verify data in provider directories to ensure the accuracy of the information and make process improvements, when necessary, to ensure the data is as accurate and up-to-date as possible.
- Use provider data within claims submission and payment processing systems to evaluate possibly incorrect data elements.
- Create a process to evaluate network adequacy that includes procedures to remedy deficiencies that are identified.
- Annually, identify all ECPs, including Indian health care providers, in each service area and develop a process to ensure that contract offers are made to each ECP and documentation of those offers is maintained in accordance with applicable Marketplace record retention requirements.

3.7 Meaningful Access

Pursuant to 45 CFR § 156.250, issuers must provide meaningful access to QHP information by ensuring the accessibility of health plan applications and notices. Documents must be accessible for individuals in accordance with the Americans with Disabilities Act (ADA) and for individuals with limited English proficiency.

3.7.1 *CMS Review Methodology*

CMS reviewed a variety of enrollee notices submitted by issuers (e.g., enrollment letters, welcome packets, termination notices, HICS letters, late premium payment notices, dental plan and health plan notices of privacy practices) and issuers' websites to determine if information critical for obtaining health insurance coverage or access to health care services was included on each notice and website. Critical information includes instructions on how to access language assistance services for individuals with limited English proficiency or individuals living with disabilities, and that these services may be accessed at no cost to the enrollee as described in 45 CFR § 155.205(c).

3.7.2 *Results*

Table 7 lists findings or observations related to this review area.

Table 7: Meaningful Access Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer sent various notices to enrollees (e.g., HICS resolution, enrollment letters, welcome packets) that omitted the required taglines for individuals with disabilities and/or limited English proficiency.

3.7.1 *Best Practices*

- Establish a process to ensure that all patient-facing notices either contain the required information in the notice templates or in an addendum attached to all notices.

3.8 Premium Rate Variations

Pursuant to 45 CFR § 156.255(b), QHP issuers are required to charge the same premium rate without regard to whether the plan is offered through an Exchange, directly from the issuer or through an agent.

3.8.1 *CMS Review Methodology*

CMS performed comparisons of similar on- and off-Exchange plan premiums to determine if the rates being charged were comparable[7] for similar plans.

3.8.2 *Results*

Table 8 lists findings or observations related to this review area.

Table 8: Premium Rate Variation Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ No findings or observations were identified related to this review area.

3.8.3 *Best Practices*

- N/A

3.9 Enrollment Periods for Qualified Individuals

Pursuant to 45 CFR § 156.260, issuers must:

- Enroll qualified individuals during the applicable annual open enrollment period;
- Make available special enrollment periods in cases of specific triggering events in accordance with 45 CFR § 155.420(d);
- Comply with the Exchange rules governing effective dates of coverage; and
- Communicate the effective date of enrollees' coverage.

[7] The definition of "comparable" for this evaluation was determined to be a variance between similar plans of less than one dollar per month.

3.9.1 *CMS Review Methodology*

CMS reviewed issuers' enrollment period written policies and procedures.

3.9.2 *Results*

Table 9 lists findings or observations related to this review area.

Table 9: Enrollment Period Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ No findings or observations were identified related to this review area.

3.9.3 *Best Practices*

- N/A

3.10 Enrollment Process for Qualified Individuals

Pursuant to 45 CFR § 156.265, issuers must adhere to the required enrollment processes for the Exchange individual market, including:

- Enrolling a consumer through the Exchanges only after receiving an eligibility determination from the Exchange;
- Safeguarding enrollment information with respect to personally identifiable information (PII);
- Ensuring the process used to complete the eligibility application complies with the Exchange privacy and security requirements;
- Providing new enrollees with enrollment information packages that meet readability and accessibility standards for individuals with disabilities or limited English proficiency;
- Reconciling enrollment files with the Exchange no less frequently than once a month; and
- Acknowledging receipt of enrollment information provided to the issuer by the Exchanges.

Within this review area, CMS also reviewed requirements related to acceptance of certain third-party payments (see 45 CFR § 156.1250). This regulation requires QHP issuers in the individual market to accept premium and cost-sharing payments from certain third parties on behalf of enrollees, including Indian tribes, tribal organizations, and urban Indian organizations; Ryan White HIV/AIDS Programs; as well as local, state, and federal government programs and their grantees.

3.10.1 *CMS Review Methodology*

CMS reviewed enrollment processes, new enrollment packages, and processes for reconciling enrollment files with the FFEs. To evaluate issuer compliance with FFE privacy and security standards, CMS reviewed the issuer's written privacy and security policies, materials for privacy and security training provided to employees and delegated and/or downstream entities, and records of individuals who completed the training. To evaluate issuer compliance with FFE third-party premium payment requirements, CMS reviewed the issuers' written premium acceptance policies and through written and

verbal communication confirmed the issuers' processes related to the acceptance of third-party payments for patient premiums.

3.10.2 *Results*

Table 10 lists findings or observations related to this review area.

Table 10: Enrollment Process Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer did not have a written process for, was not aware of, or had not been compliant with the FFE incident or breach reporting requirements as established by 45 CFR §§ 155.260 and 156.265(b)(3)(iii).

3.10.3 *Best Practices*

- Evaluate and update policies and procedures related to incident and breach reporting with respect to QHPs offered through the FFEs and include the required notification timeframes and a reporting process as appropriate.

3.11 Termination of Coverage for Qualified Individuals

Pursuant to 45 CFR § 156.270, issuers must adhere to termination of coverage processes in the individual market. These processes require QHP issuers to:

- Terminate coverage only under certain permitted circumstances;
- Provide termination of coverage notices promptly to affected enrollees, when applicable;
- Establish a policy for handling terminations of coverage due to nonpayment of premiums;
- Follow the special termination guidelines for recipients of Advance Payments of the Premium Tax Credit (APTC);
- Provide payment delinquency notices to affected enrollees;
- Maintain termination of coverage records in accordance with Exchange standards; and
- Comply with the rules for effective dates of termination of coverage.

In addition, CMS reviewed QHP non-renewal standards under this review area. Pursuant to 45 CFR § 156.290(b), if an issuer elects not to seek recertification with the Exchanges for its QHP(s), the issuer must provide written notices of termination of coverage to affected enrollees in a timely manner.

3.11.1 *CMS Review Methodology*

CMS reviewed issuers' termination of coverage written policies to determine if the policies contained the required elements. CMS also performed testing on a sample of enrollee termination notices from each issuer to determine if enrollees were notified of their terminations without undue delay, the notices contained a termination date, and the reasons for the terminations. Additionally, CMS performed a review of issuers' record maintenance written policies specific to termination of coverage. CMS also conducted performance testing on payment delinquency notices to determine whether issuers sent them within appropriate timeframes.

3.11.2 *Results*

Table 11 lists findings or observations related to this review area.

Table 11: Termination of Coverage Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer did not establish a standard written policy for the termination of enrollees due to non-payment of premium. ▪ Issuer did not send termination notices to all enrollees or such notices were sent with undue delay. ▪ Termination notices did not include a reason for the termination, an end date to the enrollees' coverage, or other required information.

3.11.3 *Best Practices*

- Regularly review termination of coverage operations to ensure processes are working as intended, and notices are sent promptly and with the required content.

3.12 Agent and Broker Oversight

Pursuant to 45 CFR § 156.340(a)(3), QHP issuers must confirm that their affiliated agents and brokers are compliant with all applicable requirements such as:

- Satisfaction of applicable FFE registration and training requirements.

3.12.1 *CMS Review Methodology*

CMS reviewed issuers' written policies and procedures related to affiliated agent/broker onboarding. CMS then cross-referenced issuers' submitted lists of National Producer Numbers (NPNs) for affiliated agents and brokers who assisted with PY 2017 enrollments against the published *CMS Agent and Broker FFE Registration Completion List for Plan Year 2017*[8] to confirm if each agent or broker had completed the required FFE registration and training. CMS also compared the PY 2017 FFE registration completion dates of those registered agents or brokers with the date of the first enrollment they assisted with for PY 2017 in order to determine if the agents or brokers were assisting with enrollments prior to having completed the FFE registration and training process.

3.12.2 *Results*

Table 12 lists findings or observations for this review area.

[8] Available at https://data.healthcare.gov/dataset/AB-Registration-Completion-List/wb6u-x2ny/data.

Table 122: Agent and Broker Oversight Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ NPNs for affiliated agents, brokers, or agencies did not match CMS' records, indicating they likely had not completed the required FFE registration and training process for PY 2017. ▪ Affiliated agents or brokers (including agent broker entities) did not complete the required FFE registration and training for PY 2017 prior to assisting individuals with enrollment in the FFEs.

3.12.3 *Best Practices*

- Regularly review CMS's agent and broker registration completion list and compare it with affiliated agents' and brokers' NPNs to ensure that agents and brokers have completed FFE registration, as required, prior to assisting consumers with FFE enrollments.

- Establish a process to educate affiliated agents and brokers found to be out-of-compliance with FFE registration and training requirements.

3.13 Delegated and Downstream Entities

Pursuant to 45 CFR § 156.340, QHP issuers must comply with standards applicable to delegated and downstream entities, including executing a delegation agreement/amendment that: 1) specifies delegated activities and reporting responsibilities; 2) provides for remedies if the downstream or delegated entity does not perform satisfactorily; and 3) conforms with the other requirements in 45 CFR § 156.340(b).

3.13.1 *CMS Review Methodology*

CMS reviewed each contract (including any amendments) with a delegated or downstream entity submitted by the FFE issuer to determine if the contract:

- Specifies the delegated activities and reporting responsibilities;
- Provides for revocation of the delegation or other remedies when HHS or the QHP issuer determines that the downstream or delegated entity has not performed satisfactorily;
- Requires compliance with all applicable statutes and regulations;
- Provides for access by HHS or its designees to the entity's books, contracts, computers, or other systems relating to the QHP issuer's obligations until 10 years from the final date of the agreement; and
- Contained these provisions no later than January 1, 2015, for existing agreements, and no later than the effective date of the agreement for agreements that were newly entered into as of October 1, 2013.

3.13.2 *Results*

Table 13 lists findings or observations related to this review area.

Table 133: Delegated and Downstream Entity Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer's downstream and delegated entity agreements (including any amendments thereto) did not include all of the language required by 45 CFR § 156.340.

3.13.3 *Best Practices*

- Review all contracts with downstream and delegated entities performing functions related to the FFEs to ensure that the language required under 45 CFR § 156.340 has been incorporated (as applicable).

- Establish oversight processes for downstream and delegated entities to ensure that they are in compliance with their contractual obligations and related FFE requirements.

3.14 Maintenance of Records

Pursuant to 45 CFR § 156.705, FFE issuers are required to comply with the FFE standards for maintenance of records. This requirement includes maintaining FFE records for a period of 10 years. Additionally, FFE issuers must make available all records that are necessary for HHS to conduct financial audits and compliance reviews.

3.14.1 *CMS Review Methodology*

CMS reviewed written policies to determine FFE issuer record-maintenance schedules and confirm compliance with the FFE 10-year record maintenance requirement. CMS also reviewed a variety of related records and documents requested from issuers.

Findings or observations related to this review area were identified due to some issuers failing to supply certain requested documents or notices that should have been maintained. This was confirmed when issuers communicated that requested documents had been created but were unavailable or not able to be located.

3.14.2 *Results*

Table 14 lists findings or observations related to this review area.

Table 14: Maintenance of Records Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer's FFE records were not available when requested.

3.14.3 *Best Practices*

- Update written record-retention policies, and provide applicable staff training, to ensure records are maintained for the required period.

3.15 Compliance Plans

Pursuant to 45 CFR § 156.715, FFE issuers are subject to compliance reviews and must provide CMS access to certain FFE records. Such records may include, but are not limited to:

- The issuer's books and contracts, including policy manuals and other plan benefit information provided to enrollees;
- The issuer's policies and procedures, protocols, standard operating procedures, or other similar manuals; and
- Any other information reasonably necessary for HHS to evaluate compliance with certification standards, assess adherence to an effective compliance plan, and determine the likelihood of fraud or abuse.

3.15.1 *CMS Review Methodology*

To evaluate compliance with these standards, CMS reviewed compliance plans submitted by issuers.

3.15.2 *Results*

Table 15 lists findings or observations related to this review area.

Table 15: Compliance Plan Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ No findings or observations were identified related to this review area.

3.15.3 *Best Practices*

- N/A

3.16 Casework

Pursuant to 45 CFR § 156.1010, FFE issuers must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS[9];
- Resolve non-urgent cases (for cases forwarded by HHS) no later than 15 calendar days after receipt of the case, and urgent cases no later than 72 hours after the case is received;
- Provide notice[10] to the complainant of the disposition of a case as soon as possible upon resolution of the case, but in no event later than 3 business days after the case is resolved; and
- Record resolution summaries in the HICS within 7 days of completion with a clear and concise explanation of how the case was resolved.

[9] CMS records casework in the Health Insurance Casework System (HICS), a web application that CMS requires issuers operating in FFEs to use for casework intake and resolution activities.
[10] To meet this requirement, notification may be verbal or written as determined most appropriate by the QHP issuer. In instances where notification is verbal, then a written notification must be provided in a timely manner to the consumer.

3.16.1 *CMS Review Methodology*

CMS reviewed the casework documentation submitted by each issuer for the sample of cases for that issuer selected by CMS for review. The submitted documentation included internal HICS case notes, resolution notices, written case narratives and screenshots of the resolution page in HICS, and written case dispositions.

Each case record was tested to determine if 1) the issuer resolved the complaint within the applicable non-urgent or urgent timeframe[11]; 2) the complainant was notified verbally or in writing within 3 business days of the case's resolution; 3) for complainants notified of the resolution verbally, written notice was also provided in a timely manner; 4) a clear and concise narrative of how the case was resolved and how and when the complainant was notified was documented in HICS; and 5) the resolution narrative was uploaded to the HICS system within 7 business days after resolution.

3.16.2 *Results*

Table 16 lists findings or observations related to this review area.

Table 16: Casework Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	▪ Issuer's cases were not closed or were not documented as such within the required timeframes as applicable based on whether they were non-urgent or urgent. ▪ Written notifications were not sent to consumers either within 3 business days or in a timely manner in cases where the initial notification was made verbally. ▪ Consumers were not notified of their case's resolutions.

3.16.3 *Best Practices*

- Regularly review casework processes to ensure cases are reviewed, researched, and resolved and to ensure that all proper documentation and notifications are made consistent with FFE regulations.

4. CONCLUSION

FFE compliance reviews in PY 2017 were conducted for fifteen FFE issuers representing fourteen distinct parent companies and nine FFE states. This included nine individual medical issuers and six SADPs. Four of the reviews were completed onsite, and the remainder through desk reviews.

Review areas that frequently included findings or observations included:

- Ensuring accurate and up-to-date provider directory information as required by 45 CFR § 156.230(b)(2),
- Reviewing agreements with downstream and delegated entities to ensure their compliance with 45 CFR § 156.340(b),

[11] Urgent cases are required to be closed within 72 hours of receipt and non-urgent cases are required to be closed within 15 calendar days of receipt.

- Completing HICS casework as required by 45 CFR § 156.1010, including recording outcomes and making appropriate notifications in a timely manner, and
- Notifying enrollees of their termination in a timely manner as required by 45 CFR § 156.270.

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2016 and 2017, CMS modified the compliance review process to increase the focus on testing operations and data rather than reviewing documented procedures. CMS also refined existing methodologies to ensure the process continues to provide data about FFE issuer compliance while remaining efficient. The insights gained from FFE compliance reviews will continue to inform future guidance and regulatory updates.