



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

Marketplace Plan Management Group
Division of Issuer Compliance and Monitoring

PY 2015 FFM Issuer Compliance Review and PY 2016 FFM Notice Review Summary Report

April 7, 2017

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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 Marketplaces (FFMs), conducts qualified health plan (QHP) issuer oversight and compliance monitoring activities in the FFMs, including FFMs in states performing plan management functions. Oversight and monitoring helps protect consumers by ensuring issuers maintain compliance with QHP certification standards and FFM requirements, identifying opportunities for improvement, and providing insight on where additional CMS guidance or direction is needed.

This report summarizes the results from two key compliance activities related to QHPs certified for Plan Year 2015 (PY 2015):¹ 1) compliance reviews and 2) reviews of renewal and discontinuation notices sent to enrollees in 2015 for the Plan Year 2016 (PY 2016) Open Enrollment period (OEP) (notice reviews). Specifically, this report provides insights on identified areas of non-compliance and potential non-compliance with CMS regulations and guidance.

1.1 Compliance Reviews

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 FFMs to ensure ongoing compliance with QHP certification standards and FFM requirements. CMS selected 32 issuers to undergo PY 2015 compliance reviews.²

The compliance reviews focused on 15 areas and involved a combination of process reviews and performance testing.³ **Table 1** identifies the 15 areas CMS reviewed as part of the PY 2015 compliance reviews. (See [Appendix A](#) for a consolidated list of regulatory standards aligned to each compliance review area.)

Table 1. PY 2015 Compliance Review Areas

Review Areas
Agent and Broker Oversight
Casework
Compliance Plans

¹ For purposes of this report, CMS defines PY 2015 as the period between January 1, 2015, and December 31, 2015.

² CMS selected issuers from the following 12 FFM states for PY 2015 compliance reviews: Alabama, Florida, Georgia, Indiana, Mississippi, North Carolina, New Jersey, Pennsylvania, South Carolina, Tennessee, Texas, and Wisconsin. CMS also selected issuers from the following five states performing plan management functions in the FFMs: Michigan, New Hampshire, Ohio, South Dakota, and Virginia. One of the thirty-two issuers volunteered to participate in a compliance review.

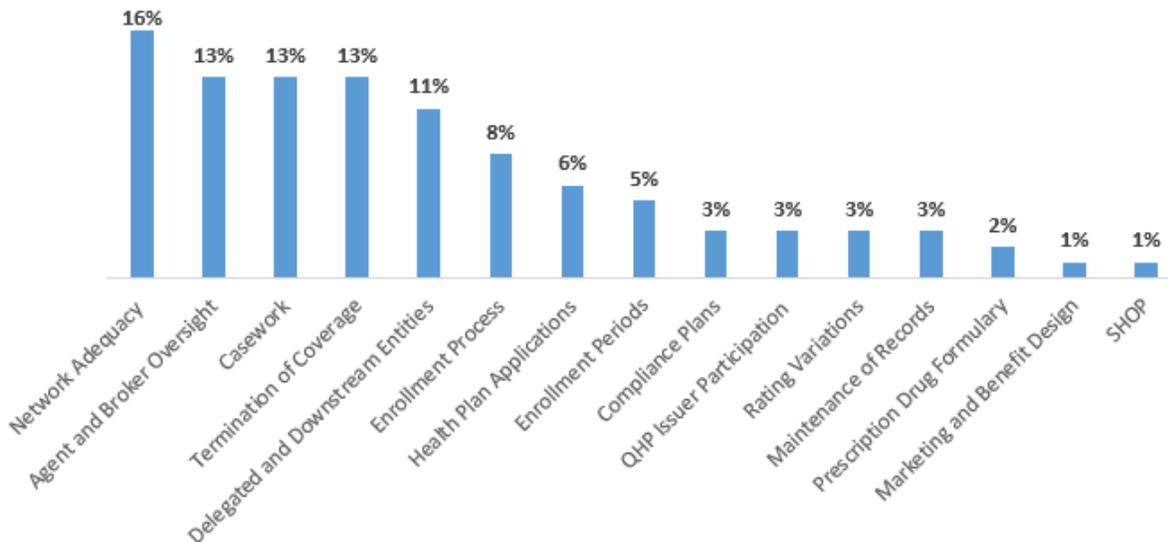
³ For the PY 2015 compliance reviews, CMS conducted performance testing in 9 of the 15 review areas, and process reviews for all review areas. The following areas did not undergo performance testing: Enrollment Periods for Qualified Individuals, Enrollment Process for Qualified Individuals, Maintenance of Records, QHP Issuer Participation General Standards, Marketing and Benefit Design, and Compliance Plans. See [Section 3](#) for more information on the differences between process reviews and performance testing.

Review Areas
Delegated and Downstream Entities
Enrollment Periods for Qualified Individuals
Enrollment Process for Qualified Individuals
Health Plan Applications and Notices (Meaningful Access)
Maintenance of Records
Marketing and Benefit Design
Network Adequacy
Prescription Drug Formulary
QHP Issuer Participation General Standards
Rating Variations
Small Business Health Options Program (SHOP) Marketplace
Termination of Coverage for Qualified Individuals

CMS calculated the percentage of total compliance review findings and observations⁴ in each review area; certain review areas had a higher percentage of findings and observations than other areas.

Figure 1 displays the distribution of compliance review findings and observations across all review areas⁵ (e.g., 16% of compliance review findings and observations related to Network Adequacy, 13% of compliance review findings and observations related to Agent and Broker Oversight).

Figure 1. Percentage of Compliance Review Findings and Observations by Review Area



⁴ Findings may result from discovery of evidence of possible non-compliance, in addition to discovery of evidence of definitive non-compliance. Observations may result from discovery of evidence of potential non-compliance, in addition to identification of areas for improvement when there is no evidence of non-compliance.

⁵ Percentages in Figure 1 may not add to 100% due to rounding.

The four review areas with the most prevalent findings and observations were Network Adequacy, Agent and Broker Oversight, Casework, and Termination of Coverage. Examples of more common findings and observations in these areas were:

- **Agent and Broker Oversight:** Compensating affiliated agents and brokers for enrolling consumers in QHPs offered through the FFMs, without verifying whether the agent or broker had completed FFM registration and training requirements;
- **Casework:** Not meeting the required timeframes for casework resolution and/or notification;
- **Network Adequacy:** Not indicating in directories whether providers were accepting new patients;
- **Network Adequacy:** Not meeting all of the essential community provider (ECP) requirements; and
- **Termination of Coverage:** Having incomplete policies around termination of coverage.

A more detailed summary of the compliance review findings and observations is located in [Section 3](#), and summary statistics are located in [Appendix B](#).

1.2 Notice Reviews

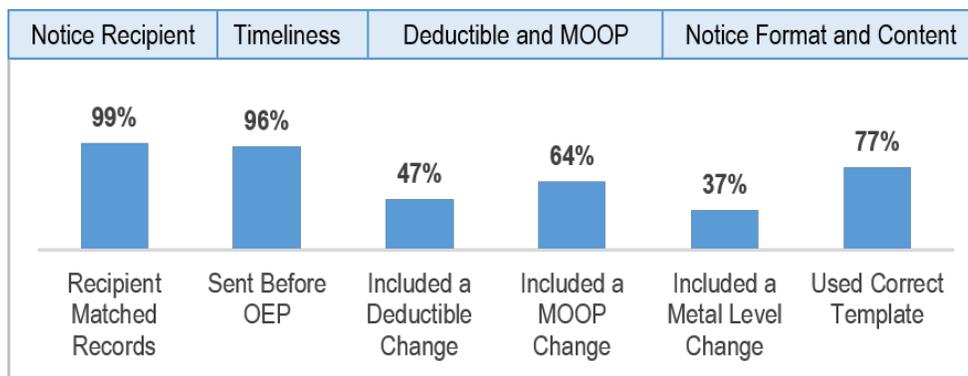
Issuers in the Marketplaces must adhere to 45 CFR 147.106 and 156.1255, which require them to send renewal and discontinuation notices, as appropriate, to their enrollees in a form and manner that complies with CMS guidance (see the September 2, 2014 bulletin).⁶ CMS reviewed a sample of 1,012 renewal and discontinuation notices sent to enrollees in 2015 for the PY 2016 OEP. The sample was comprised of notices from 14 issuers in the FFMs and 10 issuers in states performing plan management functions. CMS reviewed the notices against requirements in the following five areas:

1. **Notice Recipient:** Was the notice sent to the correct consumer based on CMS' records?
2. **Timeliness:** Was the notice sent before the first day of the PY 2016 OEP?
3. **Deductible and Maximum Out-of-Pocket (MOOP):** When a MOOP or deductible change occurred, was the change mentioned? Was the new amount communicated in either the notice or supplemental documents, such as the Summary of Benefits and Coverage (SBC)?
4. **Notice Format and Content:** Did the notice comply with content and formatting requirements?
5. **Benefit Cost Structure and Cost-Sharing Changes:** Were changes in cost structure and cost-sharing amounts accurately communicated in either the notice or supplemental documentation across eight benefit areas (inpatient and hospital services, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs)?

⁶ The September 2, 2014 bulletin is available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.pdf>. More recent related guidance is available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-090216.pdf>.

Figure 2 provides an overview of rates of compliance for the first four of the five review areas described above.⁷

Figure 2. Overview of Select Notice Review Rates of Compliance



The fifth review area (Benefit Cost Structure and Cost-sharing Changes) is not included in **Figure 2** because the results in the figure are percentages of notices adhering to *singular requirements*, while the results for the fifth review area include *multiple subparts* that would not be easily depicted in the format used in **Figure 2**. Please refer to [Section 4.2.5](#) for more detailed results regarding the cost-sharing changes for the eight benefit types that were part of the fifth review area.

Key findings and observations of the CMS review of the sample renewal and discontinuation notices included:

- **Notice Recipient:** Nearly all issuers (99%) were compliant with the requirement to send notices to the correct recipients.
- **Timeliness:** Nearly all notices (96%) were compliant with the requirement to be sent before the PY 2016 OEP began on November 1, 2015.
- **Deductible and MOOP:** About half of the notices reviewed contained information about deductible changes (when there was a deductible change) as required. About two-thirds of the notices contained information about MOOP changes (when there was a MOOP change) as required. Some issuers did not communicate the correct MOOP or deductible, or a change in MOOP or deductible.
- **Notice Format and Content:**
 - Most issuer notices used the correct template as provided by CMS guidance. Fourteen percent of the reviewed notices used the incorrect standard notice for their plan status (e.g., issuers used the standard notice for “renewal in a different product” when they should have used the standard notice for “renewal in a different plan within the same product”).

⁷ Three of the categories in this exhibit—Included a Deductible Change, Included a MOOP Change, and Included a Metal Level Change—note the percentage of notices that contained that change, when expected to do so based on CMS guidance. In other words, some notices may not have included reference to a change simply because there was no change.

- About one-third (37%) of the notices, or supplemental materials, that should have contained information about metal level changes did so.
- **Benefit Cost Structure and Cost-sharing Changes:**
 - Issuers did not communicate cost structure changes for five of the eight reviewed benefit areas in their renewal notices to enrollees. None of the notices that CMS reviewed for benefits information included information on cost structure changes for emergency services, primary care, specialist visits, specialty drugs, and generic drugs.⁸
 - Issuers provided enrollees with a cost-sharing amount (e.g., copay or coinsurance amount) that matched CMS’ records (i.e., the amount presumed to be correct) about half of the time.

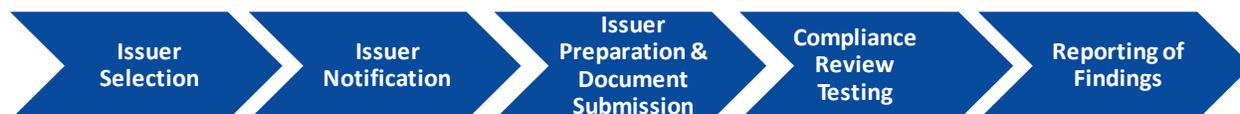
A summary of these notice review findings and observations is located in [Section 4](#) and detailed results/graphics are located in [Appendix C](#).

⁸ Per the September 2, 2014 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.” CMS chose the eight selected benefit areas as a reasonable representation of “significant changes to coverage.” Some issuers may not have had cost structure changes for some of these benefit areas.

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 FFM to ensure ongoing compliance with requirements for QHP certification under 45 CFR Part 156 and other FFM operational standards.⁹ FFM 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 as displayed in **Figure 3**.

Figure 3. The FFM Compliance Review Process



CMS selects issuers for compliance reviews based on performance data and ongoing monitoring activities. For PY 2015,¹⁰ CMS conducted compliance reviews of 32 issuers.¹¹ CMS selected 31 of these issuers; an additional issuer volunteered to participate in a compliance review. **This report refers to these reviews as the PY 2015 compliance reviews.**

Beginning in April 2015, CMS conducted kick-off calls to notify issuers of their selection, discuss the compliance review process, and inform them of any documentation needed prior to the start of the reviews. After reviewing the requested documentation, CMS conducted interviews with issuer staff about their FFM operations. **Figure 4** illustrates issuer characteristics for the PY 2015 compliance reviews.¹²

⁹ In March 2015, CMS released the *Key Priorities for FFM Compliance Reviews for the 2015 Benefit Year* (Key Priorities), which set forth a list of regulatory standards that CMS planned to include in the 2015 compliance reviews. This document is available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032715_508.pdf

¹⁰ For purposes of this report, CMS defines PY 2015 as the period between January 1, 2015, and December 31, 2015. For the 2014 and 2015 calendar years, CMS did not take enforcement action during those calendar years if an issuer made good faith efforts to comply with applicable requirements (45 CFR 156.800(c)).

¹¹ The 32 issuers in this report relate to 32 specific issuer IDs, which represent fewer than 32 unique parent organizations.

¹² The 32 issuers represented in Figure 4 includes one issuer offering a SHOP Marketplace QHP that was reviewed.

Figure 4. Overview of Issuers Reviewed in PY 2015



The PY 2015 compliance reviews consisted of 9 onsite reviews (encompassing 15 issuers) and 17 desk reviews.¹³ During each review, CMS: 1) reviewed issuers' policies and procedures for all review areas within the scope of the review, and 2) performed testing for 9 of the 15 review areas to assess compliance with FFM-specific regulations for review areas within the scope of the review by using 100% of available data or a random sample. [Section 3](#) provides the results of the PY 2015 compliance reviews by review area.

¹³ 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, webinars, and e-mail to collect the necessary information and documents for review.

3. Compliance Review Results

Findings and observations¹⁴ contained in this report align with the 15 review areas noted in **Table 1** and associated regulatory standards. **Tables 2** through **16** present findings and observations for each of the 15 review areas. Findings may result from discovery of evidence of possible non-compliance, in addition to discovery of evidence of definitive non-compliance. Observations may result from discovery of evidence of potential non-compliance, in addition to identification of areas for improvement when there is no evidence of non-compliance.

CMS classified findings and observations¹⁵ based on the type of **review methodology** employed:

- **Process Review:** Review of issuers' policies and procedures for review areas within the scope of the PY 2015 compliance review. Throughout the process, CMS requested and reviewed applicable policies and procedures established and provided by the issuer.
- **Performance Testing:** Testing to assess issuers' compliance with FFM-specific regulations for review areas within the scope of the PY 2015 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 made based on the test being performed.

For the PY 2015 compliance reviews, CMS conducted both review methodologies (i.e., process reviews and performance testing) for some areas and only employed one of the review methodologies for other areas.

3.1 Results by Review Area

This section describes the standards and requirements in each of the 15 review areas, the methodology CMS used to review issuer compliance, and any associated findings and observations. Refer to [Appendix B](#) for a more detailed summary of the findings and observations with graphics for each review area.

3.1.1 Agent and Broker Oversight

Under 45 CFR 156.340(a)(3), issuers must confirm their affiliated agents and brokers are compliant with all applicable requirements, including standards set forth in 45 CFR 155.220, such as:

- Satisfaction of applicable FFM registration and training requirements;
- Maintenance of licensure and good standing in each state in which the agent or broker operates;
- Execution of the applicable FFM Privacy/Security Agreement and (if applicable) the General Marketplace Agreement; and
- Use of the required disclaimers if an agent or broker uses a website other than HealthCare.gov to assist with QHP selection for enrollment through the FFMs.

¹⁴ "Findings" represent a risk to compliance for which CMS may request a work plan to correct. The tables for some review areas also include "observations," for which CMS does not request the issuer to produce a work plan.

¹⁵ Review areas may contain findings, observations, or both, depending on testing results.

3.1.1.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed policies and procedures related to agent/broker agreements, cross-referenced the agent/broker National Producer Numbers (NPNs) provided by issuers against CMS’ records, and reviewed procedures to validate whether issuers verified if affiliated agents and brokers completed applicable FFM training and registration requirements.

CMS also conducted performance testing using NPNs to evaluate: 1) whether issuers verified if their affiliated agents and brokers received compensation, but never completed applicable FFM registration requirements, and 2) whether issuers verified if their affiliated agents and brokers received compensation prior to completing the applicable FFM registration requirements.

3.1.1.2 Results

Table 2 lists findings and observations related to PY 2015 for this review area.

Table 2. Agent and Broker Oversight Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ NPNs for affiliated agents, brokers, or agencies did not match CMS’ records.
Process Review	<ul style="list-style-type: none"> ▪ Issuer’s agent and broker oversight policy did not include: <ul style="list-style-type: none"> – Validation of completion of applicable FFM training, and/or – A requirement to comply with applicable agent/broker FFM training and registration standards. ▪ Issuer’s agent and broker oversight policy was: <ul style="list-style-type: none"> – Not approved by management, and/or – Not in effect for full PY 2015. ▪ Issuer’s agent and broker agreement templates did not include FFM-specific language.

In PY 2015, CMS found that fewer issuers (25%) had incomplete policies related to agent/broker oversight (compared to 39% in PY 2014). CMS also found more issuers validated agent/broker completion of applicable FFM training and registration requirements in PY 2015 than in PY 2014.

3.1.2 Casework

Under 45 CFR 156.1010, issuers must:

- Investigate and resolve, as appropriate, consumer cases forwarded by the Department of Health and Human Services (HHS);¹⁶
- Investigate and resolve issues received directly from the complainant through their internal customer service process;
- 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;

¹⁶ CMS records casework in the Health Insurance Casework System (HICS), a web application that CMS requires issuers operating in FFM to use for casework intake and resolution activities.

- Document a resolution summary of the case (for cases forwarded by HHS) no later than seven business days after resolution of the case; and
- Notify the complainant as soon as possible upon resolution of the case (for cases forwarded by HHS), but no later than three business days after the case is resolved.

3.1.2.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed issuer policies for addressing casework through the Health Insurance Casework System (HICS). CMS expanded the review for PY 2015 to include performance testing of casework processes for PY 2015. Specifically, CMS reviewed casework documentation submitted by issuers, including internal casework notes and screenshots of resolution pages in HICS, to validate compliance with casework requirements.

3.1.2.2 Results

Table 3 lists findings and observations related to this review area.¹⁷

Table 3. Casework Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's casework documentation was not compliant with casework resolution and/or notification requirements.
Process Review	<ul style="list-style-type: none"> ▪ Issuer did not have a policy to investigate and resolve HICS cases in a timely manner per HICS resolution requirements, or its policy was inadequate. ▪ Issuer's casework policy: <ul style="list-style-type: none"> - Did not include complainant notification and resolution summary requirements, and/or - Was not in effect for full PY 2015.

In PY 2015, CMS had several new findings and observations across issuers due to performance testing against casework requirements (e.g., several issuers needed more than 15 calendar days to resolve non-urgent cases). CMS also found fewer issuers had incomplete casework policies (22% in PY 2015, compared to 61% in PY 2014).

3.1.3 Compliance Plans

Under 45 CFR 156.715, issuers are subject to compliance reviews and must provide CMS access to certain FFM 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 measure the likelihood of fraud or abuse.

¹⁷ Additional information is located in [Appendix B](#).

3.1.3.1 CMS Review Methodology

To evaluate issuer compliance against these standards, CMS reviewed compliance plans (if available) submitted by issuers.

3.1.3.2 Results

The PY 2015 review of compliance plans only resulted in observations. **Table 4** lists observations related to this review area.

Table 4. Compliance Plan Observations

Review Methodology	Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuer's compliance plan: <ul style="list-style-type: none"> – Did not contain the seven elements recommended by HHS for an effective compliance program;¹⁸ – Was not approved by management; and/or – Contained no effective date, so it could not be verified to be in effect for full PY 2015. ▪ Issuer's existing policy to review and update compliance plan was incomplete.

3.1.4 Delegated and Downstream Entities

Under 45 CFR 156.340, issuers must comply with standards applicable to delegated and downstream entities, including:

- Ensuring delegated/downstream entities do not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs; and
- Executing a delegation agreement/amendment that specifies delegated activities and reporting responsibilities, provides for remedies if the delegated entity does not perform satisfactorily, and otherwise conforms with the requirements listed in 45 CFR 156.340(b).

3.1.4.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed policies and procedures for oversight of delegated and downstream entities. Additionally, CMS conducted performance testing by reviewing sample delegation agreements/amendments (e.g., vendor contracts) to determine whether they met key requirements, such as 45 CFR 156.340(b), which contains FFM-specific requirements related to issuers' agreements with downstream and delegated entities, including those related to:

- Record maintenance language consistent with the 10-year FFM requirement; and
- Permission for HHS or its designee to access records to review them for compliance with federal regulations.

3.1.4.2 Results

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

¹⁸ See 64 Fed. Reg. 61893, in which the HHS Office of Inspector General specified seven elements for an effective compliance program for Medicare+Choice (now known as Medicare Advantage) organizations.

Table 5. Delegated and Downstream Entity Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's delegation agreements/amendments did not address FFM-specific requirements.
Process Review	<ul style="list-style-type: none"> ▪ Issuer had no policy for delegated entity oversight. ▪ Issuer's delegated entity oversight policy: <ul style="list-style-type: none"> – Did not include FFM-specific requirements, and/or – Was not in effect for full PY 2015. ▪ Issuer's policy to oversee and monitor downstream and delegated entities was incomplete.

Performance testing in PY 2015 revealed more issuers (81%) had delegation agreements/amendments that did not include all of the requirements listed under 45 CFR 156.340(b) than in PY 2014 (61%). Process review testing in PY 2015 indicated a lower percentage of issuers (6%) without delegated entity oversight policies in effect than in PY 2014 (17%).

3.1.5 Enrollment Periods for Qualified Individuals

Under 45 CFR 156.260, issuers must:

- Enroll qualified individuals during the initial and subsequent annual OEPs;
- Allow for special enrollment periods (SEPs) in cases of specific triggering events;
- Comply with the FFM rules governing effective dates of coverage; and
- Accurately communicate effective dates of coverage.

3.1.5.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed issuers' enrollment period policies and procedures.

3.1.5.2 Results

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

Table 6. Enrollment Period Findings and Observations

Review Methodology	Findings and Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuer did not have a policy that defined annual OEPs and/or SEPs, and effective dates of coverage. ▪ Issuer's enrollment period policy did not include: <ul style="list-style-type: none"> – A complete list of SEP-triggering events; and/or – FFM requirements, such as effective dates of coverage. ▪ Issuer's enrollment period policy was: <ul style="list-style-type: none"> – Not approved by management, – Not in effect during full PY 2015, and/or – Not finalized for full PY 2015.

CMS found that in PY 2015 fewer issuers (19%) had no policy or procedure regarding enrollment periods for qualified individuals than in PY 2014 (35%).

3.1.6 Enrollment Process for Qualified Individuals

Under 45 CFR 156.265, issuers must adhere to the required enrollment processes for the FFM individual market, including:

- Enrolling a consumer through the FFMs only after receiving an eligibility determination from the FFMs;
- Safeguarding enrollment information with respect to personally identifiable information (PII);
- 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 FFMs no less frequently than once a month; and
- Acknowledging receipt of enrollment information provided to the issuer by the FFMs.

Within this review area, CMS included the review of acceptance of certain third-party payments (45 CFR 156.1250) for the first time in connection with PY 2015. This regulation requires issuers to accept premium and cost-sharing payments from certain third parties on behalf of enrollees, including Indian tribes, tribal organizations, and urban Indian organizations; a Ryan White HIV/AIDS Program; as well as local, state, and Federal Government programs.

3.1.6.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed enrollment policies and procedures, new enrollment packages, and policies and procedures for reconciling enrollment files with the FFMs. To evaluate issuer compliance with FFM privacy and security standards, CMS reviewed 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.

3.1.6.2 Results

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

Table 7. Enrollment Process Findings and Observations

Review Methodology	Findings and Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuer did not have a policy for: <ul style="list-style-type: none"> – Processing advanced payment of the premium tax credit (APTC), cost-sharing reduction (CSR) payments, or acceptance of third-party premium payments, and/or – Processing of premium payments. ▪ Issuer’s privacy and security policy did not contain PII safeguarding requirements. ▪ Issuer’s enrollment process policy did not address FFM requirements regarding potential breaches. ▪ Employee training did not include FFM privacy and security requirements. ▪ Issuer’s enrollment policy did not address: <ul style="list-style-type: none"> – Eligibility, – Individual premium payment processing, and/or – Third party premium payment. ▪ Issuer’s enrollment policy was not approved by management. ▪ Issuer’s procedures for data breach notification did not meet FFM requirements. ▪ The following were not in effect for full PY 2015: <ul style="list-style-type: none"> – Issuer’s enrollment eligibility policy,

Review Methodology	Findings and Observations
	<ul style="list-style-type: none"> - Issuer’s enrollment reconciliation policy, - Issuer’s policy to ensure compliance with third-party premium payment requirements, - Issuer’s premium payment processing policy, and/or - Issuer’s policy related to data breach protection.

CMS found there were fewer enrollment process findings and observations across issuers in PY 2015 than in PY 2014. Fewer issuers had incomplete policies (13% in PY 2015, compared to 48% in PY 2014). The percentage of issuers with no formal enrollment policy (including policy for acceptance and processing of third-party payments) decreased from 74% in PY 2014 to 28% in PY 2015.

3.1.7 Health Plan Applications and Notices (Meaningful Access)

Under 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.

3.1.7.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed a variety of notices that issuers sent to enrollees (e.g., enrollment letters, welcome packets, termination notices, HICS letters, late premium payment notices, dental plan and health plan notices of privacy practices) to determine whether they contained the required taglines.

3.1.7.2 Results

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

Table 8. Health Plan Application and Notices Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer’s HICS resolution notices did not include language taglines. ▪ Issuer sent various notices to enrollees (e.g., enrollment letters, welcome packets) that omitted the required taglines for individuals with disabilities and/or limited English proficiency.

3.1.8 Maintenance of Records

Under 45 CFR 156.705, issuers are required to comply with the FFM standards for maintenance of records. This requirement includes maintaining FFM records for a period of 10 years. Additionally, issuers must maintain and make available all documents that are necessary for HHS to audit financial records related to an issuer’s participation in the FFMs so the government can evaluate the ability of issuers to bear the risk of potential financial losses.

3.1.8.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed policies to determine issuer record maintenance schedules and compliance with the FFM-required 10-year record maintenance period.

3.1.8.2 Results

In PY 2015, CMS found that some issuer policies were incomplete because they did not include reference to the 10-year maintenance requirement for FFM records. **Table 9** lists findings and observations related to this review area.

Table 9. Maintenance of Records Findings and Observations

Review Methodology	Findings and Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuer’s record maintenance policy was incomplete. ▪ Issuer’s record maintenance policy did not reflect the FFM-required 10-year maintenance period and contained no effective date. ▪ Issuer’s record maintenance policy was not in effect for full PY 2015.

CMS found that fewer issuers (22%) had incomplete policies in PY 2015 than in PY 2014 (35%). In addition, fewer issuers had record maintenance policies that were not in effect for the full plan year (3% in PY 2015, compared to 30% in PY 2014).

3.1.9 Marketing and Benefit Design

Under 45 CFR 156.225(b), issuers may not employ marketing practices or benefit designs that have the effect of discouraging enrollment of individuals with significant health needs in QHPs. Implementation of non-discrimination policies documents an issuer’s commitment to not discriminate against individuals belonging to protected classes.

3.1.9.1 CMS Review Methodology

To evaluate issuer compliance against these standards, CMS reviewed issuers’ policies and procedures on implementation and monitoring of non-discriminatory practices in the development of plan benefits, including coverage and limitations. CMS also reviewed policies outlining non-discrimination practices for marketing activities.

3.1.9.2 Results

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

Table 10. Marketing and Benefit Design Findings and Observations

Review Methodology	Findings and Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuers’ non-discrimination policies for marketing and plan benefit design were not in effect for full PY 2015.

In PY 2014, issuers had findings and observations regarding non-discrimination policies that did not include language on employee self-reporting of non-compliance. While there were no similar findings in PY 2015, CMS noted that some issuers did not have a policy in effect to prevent employing discriminatory practices in the development of plan benefits.

3.1.10 Network Adequacy

Under 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 a provider directory available to the FFM for publication online and providing a hard copy upon request; and
- Identifying which providers are not accepting new patients in the provider directory.

Under 45 CFR 156.235, issuer networks must also have a sufficient number and geographic distribution of essential community providers (ECPs). An ECP is a provider that serves predominantly low-income, medically underserved individuals. Issuers must satisfy the following criteria:

- Contract with at least the minimum percentage specified by HHS (for PY 2015,¹⁹ 30%) of available ECPs in each plan's service area to participate in the plan's provider network or meet the alternate ECP standard described in 45 CFR 156.235(b);
- 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.

3.1.10.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed hard copy and electronic provider directories and associated policies and procedures. CMS expanded performance testing in this review area in PY 2015 to include a comparison of the issuer's ECP list against the HHS 2015 Non-Exhaustive List of ECPs, and a review of documentation of ECP contract offers. CMS conducted observational reviews of issuer-reported data, including network analytics reports, other network accessibility analyses, and provider network audits.

3.1.10.2 Results

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

¹⁹ 2015 Letter to Issuers in the Federally-facilitated Marketplaces, Chapter 2, Section 4, subsection i, available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

Table 11. Network Adequacy Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's ECP list did not meet all ECP contract offer requirements (e.g., Indian health care providers were not offered contracts for PY 2015). ▪ Issuer provider directories: <ul style="list-style-type: none"> – Did not include the date of the most recent update, – Did not indicate whether providers are accepting new patients, and/or – Were incorrect or out-of-date (e.g., sampled providers were no longer in practice and/or had incorrect contact information). ▪ Issuer published inconsistent provider information between online and hard copy directory. ▪ Network analytics report, provider network audits, and other network accessibility analyses self-identified potential service areas with insufficient provider coverage.
Process Review	<ul style="list-style-type: none"> ▪ Issuer does not have a policy for maintaining the provider directory. ▪ Issuer's policy for maintaining an updated provider directory did not include a process to verify whether providers were accepting new patients. ▪ Issuer's policy for maintaining provider directory was not in effect for full PY 2015.

As compared to PY 2014, CMS found that more issuers had policies in place in PY 2015 to document their procedures for maintaining the accuracy of their provider directories. In addition, CMS found there were fewer issuers with incomplete policies (13% in PY 2015, compared to 39% in PY 2014), as well as fewer issuers with policies not in effect for the entire plan year (16% in PY 2015, compared to 48% in PY 2014).

3.1.11 Prescription Drug Formulary

Under 45 CFR 156.122, health plans provide an essential health benefits (EHB) package with respect to prescription drugs if they, among other things:

- Cover 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;
- Submit their formulary drug list to the FFM, the state, or the Office of Personnel Management (OPM); and
- Have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.

Under 45 CFR 156.225(b), issuers may not employ marketing practices or benefit designs that have the effect of discouraging enrollment of individuals with significant health needs in QHPs. In addition, 45 CFR 156.125 prohibits issuers from establishing a benefit design that discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

3.1.11.1 CMS Review Methodology

CMS added review of prescription drug formularies to the protocol for the PY 2015 compliance reviews. To evaluate issuer compliance in this review area, CMS reviewed policies and procedures related to each of the selected issuers' prescription drug formularies. CMS also made observations based on comparing each of the selected issuers' Prescription Drug Templates,

submitted as a part of the PY 2015 QHP application process, to the issuer’s online formulary to determine whether there were significant changes to the formulary since certification that may be prohibited by non-discrimination requirements specified at 45 CFR 156.125 and 156.225(b).

3.1.11.2 Results

Table 12 lists findings and observations related to this review area.

Table 12. Prescription Drug Formulary Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer’s online formulary omitted drug restriction requirements. ▪ Issuer’s formulary design contained significant changes since certification. ▪ Changes to drug list appeared to go beyond mid-year maintenance updates to drug coverage. ▪ Changes to formulary may be discriminatory due to the type and number of drugs that were deleted from the formulary.
Process Review	<ul style="list-style-type: none"> ▪ Issuer’s formulary management policy was not consistent with drug tier information on online formulary. ▪ Issuer’s formulary policy was not in effect for full PY 2015.

3.1.12 QHP Issuer Participation General Standards

Under 45 CFR 156.200, FFM participation standards require issuers to, among other things:

- Have each QHP certified by the FFM in which it is being offered;
- Comply with FFM processes, procedures, and requirements under Subpart K of Part 155 and, in the small group market, 45 CFR 155.705;
- Offer at least one Gold and one Silver plan through the FFM, and child-only coverage options for each non-catastrophic QHP;
- Not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation;
- Provide the same agent and broker compensation for similar coverage offered inside and outside the FFMs; and
- Comply with SHOP Marketplace participation provisions.

3.1.12.1 CMS Review Methodology

To evaluate issuer compliance against these standards, CMS reviewed non-discrimination policies to ensure that the policies were in place and available to enrollees, agents and brokers, and employees. CMS also reviewed agent and broker compensation policies, comparing amounts paid for on- and off-FFM coverage, subscriber agreements, and lists of the QHPs (by type) offered under the participating issuer IDs.

3.1.12.2 Results

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

Table 13. QHP Issuer Participation General Standards Findings and Observations

Review Methodology	Findings and Observations
Process Review	<ul style="list-style-type: none"> ▪ Issuer did not have a policy indicating the issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation. ▪ Issuer’s agent and broker compensation policies differ for similar QHP products offered on vs. off the FFMs. ▪ Issuer’s non-discrimination policy: <ul style="list-style-type: none"> – Did not include the protected classes of color and gender identity, and/or – Was not in effect for full PY 2015. ▪ Issuer’s subscriber agreement did not address all protected classes (e.g., gender identity).

CMS found the percentage of issuers that did not have non-discrimination policies in effect for the full plan year was lower in PY 2015 (9% in PY 2015 and 30% in PY 2014).

3.1.13 Rating Variations

Under 45 CFR 156.210(c) and 156.255, an issuer must comply with premium rate setting standards, including:

- Submitting to the FFM a justification for a rate increase prior to the implementation of the increase and prominently posting the justification on its website; and
- Providing parity with respect to the cost of coverage offered inside and outside the FFMs by charging the same premium rate without regard to whether the plan is offered through the FFMs, directly from the issuer, or through an affiliated agent or broker.

3.1.13.1 CMS Review Methodology

CMS reviewed issuer premium rate setting policies to evaluate issuer compliance in this review area. CMS also expanded performance testing specific to rate justification by testing whether issuers posted rate increase justifications on their websites or links to notices on HealthCare.gov prior to implementation.

3.1.13.2 Results

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

Table 14. Rating Variations Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did not post the justification for a premium rate increase on its website.
Process Review	<ul style="list-style-type: none"> ▪ Issuer’s premium rate policy was not approved by management.

In PY 2015, CMS found that all issuers had policies or procedures for premium rate setting; by comparison, in PY 2014, 17% of issuers had no policies or procedures in place for this area. However, several issuers did not post premium rate justifications. Additionally, in PY 2014, CMS found that 36% of issuers did not have rate setting policies in effect for the full plan year; by comparison, in PY 2015, only 6% of issuers did not have such policies in effect for the full plan year.

3.1.14 SHOP Marketplace

The SHOP Marketplace helps employers provide health coverage to their employees and is generally open to employers with 1 to 50 full-time and full-time-equivalent employees, although eligibility requirements vary by state. Under 45 CFR 156.285, issuers offering a QHP through an FF-SHOP are subject to additional requirements, such as:

- Enrolling a qualified employee in accordance with the qualified employer's initial and annual employee OEPs as described in 45 CFR 155.725 (including the provision of SEPs when necessary); and
- Complying with termination of coverage processes as specified in 45 CFR 156.285(d).

CMS also included review of meaningful access standards under 45 CFR 156.250 and agent and broker oversight standards under 45 CFR 156.340.²⁰

3.1.14.1 CMS Review Methodology

CMS included the review of one issuer’s FF-SHOP QHP standards for the first time in 2015. To evaluate issuer compliance in this review area, CMS evaluated the issuer’s SHOP policies and procedures; reviewed the NPNs of agents, brokers, and agencies that facilitated enrollments and/or received compensation for enrollments through the FF-SHOP in PY 2015; and evaluated issuer notices sent to FF-SHOP enrollees to determine if they met timeliness and language/disability access requirements per 45 CFR 156.250.

3.1.14.2 Results

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

Table 15. SHOP Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ NPNs for affiliated agents, brokers, or agencies that facilitated enrollments through the FF-SHOPs did not match CMS records for having completed FFM training and registration requirements. ▪ Issuer sent notices to FF-SHOP enrollees that omitted required taglines for individuals with disabilities and/or limited English proficiency. ▪ Issuer did not send termination notices promptly.
Process Review	<ul style="list-style-type: none"> ▪ Issuer’s FF-SHOP enrollment policy was not in effect for full PY 2015. ▪ Issuer’s FF-SHOP termination policy was not in effect for full PY 2015.

²⁰ See sections 3.1.1 and 3.1.7 for explanation of authority and review methodology.

3.1.15 Termination of Coverage for Qualified Individuals

Under 45 CFR 156.270, issuers must adhere to termination of coverage processes in the individual market. These processes require 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 APTC;
- Provide payment delinquency notices to affected enrollees;
- Maintain termination of coverage records in accordance with FFM-specific 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. Under 45 CFR 156.290(b), if an issuer elects not to seek recertification with the FFMs for its QHP, the issuer must provide written notices of termination of coverage to affected enrollees in a timely manner.

3.1.15.1 CMS Review Methodology

To evaluate issuer compliance in this review area, CMS reviewed issuer policies on enrollee termination and record maintenance policies specific to termination of coverage. Performance testing in this area was new for 2015. Specifically, CMS reviewed enrollee termination notices to determine if they satisfied timeliness requirements and included a reason for the coverage termination. CMS also conducted performance testing on payment delinquency notices to determine whether issuers sent them within appropriate timeframes. Additionally, CMS evaluated discontinuation and non-renewal policies to assess issuer compliance with non-renewal notice requirements.

3.1.15.2 Results

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

Table 16. Termination of Coverage Findings and Observations

Review Methodology	Findings and Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Dates of termination in termination notices were inconsistent with dates of termination in the issuer's file. ▪ Issuer's termination notices for non-payment of premium contained inaccurate premium information. ▪ Issuer sent termination notices with undue delay. ▪ Issuer sent termination notices to enrollees that did not include: <ul style="list-style-type: none"> – Reasons for terminations and/or – Termination effective dates.
Process Review	<ul style="list-style-type: none"> ▪ Issuer does not have a policy for: <ul style="list-style-type: none"> – Non-recertification of a QHP and/or – Termination of coverage. ▪ Issuer's QHP non-recertification policy was not dated or approved. ▪ Issuer's termination of coverage policy was incomplete. ▪ Issuer's policy to ensure compliance with termination record maintenance requirement was incomplete. ▪ Issuer's termination of coverage policy did not include required language regarding all circumstances for termination (e.g., policy omits termination because of fraud).

Review Methodology	Findings and Observations
	<ul style="list-style-type: none">▪ The following were not in effect for full PY 2015:<ul style="list-style-type: none">- Issuer's discontinuation policy,- Issuer's policy regarding maintenance of termination records, and- Issuer's termination of coverage policy.

In PY 2015, CMS found that fewer issuers (53%) had incomplete termination policies, compared to 70% of issuers in PY 2014.

4. Renewal and Discontinuation Notice Reviews

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.

Issuers are required to send renewal and product discontinuation notices in a form and manner specified by CMS in the September 2, 2014 bulletin. The bulletin included templates with fields and information to inform consumers of coverage changes (e.g., changes in deductibles, cost sharing) for the next plan year.

To evaluate issuer compliance with this bulletin, CMS reviewed renewal and discontinuation notices and supporting documentation that issuers participating in the FFMs provided to consumers. The scope of the review included the following five areas, which CMS determined to be the most critical in ensuring consumers' 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.²¹

CMS reviewed two categories of criteria: 1) requirements explicitly stated in regulations and/or CMS sub-regulatory guidance, or 2) best practices based on consumer protections and/or subjective interpretation of CMS guidance terminology (e.g., "significant changes in coverage").

This section provides an overview and results of the review that CMS performed on the notices sent to consumers in 2015 regarding Open Enrollment for PY 2016, referred to in this report as the PY 2016 notice review.²²

4.1 Issuer Selection and Review Method

CMS reviewed 1,012 notices representing 24 issuers.²³ CMS identified and categorized issuers for the PY 2016 notice review based on the types of changes issuers made to their QHPs from PY 2015 to PY 2016.²⁴ CMS then made a final selection of plans using a random sample from that pool.

Issuers submitted copies of renewal and discontinuation notices for specified enrollees, along with all supplemental documentation, such as the Summary of Benefits and Coverage (SBC) or a

²¹ CMS reviewed eight benefit areas: inpatient (hospital), emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.

²² For purposes of this report, CMS defines PY 2016 as the period between January 1, 2016, and December 31, 2016.

²³ CMS' review excluded SADPs and Multi-State Plans. As noted in Section 1.2, the sample was comprised of 14 issuers in FFMs and 10 issuers in states performing plan management functions.

²⁴ CMS selected issuers through a combination of risk-based and stratified random sampling. This process ensured diverse representation of notices regarding QHPs that were renewed, discontinued, or had metal level changes.

letter regarding coverage changes other than those documented in the standard notice that accompanied renewal and discontinuation notices provided to enrollees.²⁵

4.2 Notice Review Results

The following sections describe CMS' findings and observations in each of the five areas for issuers (see [Section 4.0](#)). Within each area, findings may result from discovery of evidence of possible non-compliance, in addition to discovery of evidence of definitive non-compliance. Observations may result from discovery of evidence of potential non-compliance, in addition to identification of areas for improvement when there is no evidence of non-compliance

4.2.1 Notice Format and Content

Issuers renewing coverage or discontinuing a product must provide written notice in a form and manner specified by CMS,²⁶ unless the state in which the issuer operates requires use of a different notice.²⁷ In the September 2, 2014 bulletin, CMS requires that issuers include the following information as part of the standard notice template in both renewal or discontinuation notices, when 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);²⁸
- 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 FFMs in specific timeframes and channels, and changes to CSR.

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.

4.2.1.1 CMS Review Methodology

CMS selected 1,012 sample notices to evaluate whether issuers used the correct templates.²⁹ 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.

²⁵ CMS selected a random sample of up to 20 notices per QHP from a file of Subscriber IDs pulled from enrollment data.

²⁶ As detailed in the standard notices in the September 2, 2014 bulletin, available at:

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.pdf>

²⁷ No issuers operating in a state with different notice requirements were included in this review.

²⁸ This section may also refer to enclosed supplemental materials.

²⁹ The plan's status determines which standard notice the issuer should use, per the September 2, 2014 bulletin.

CMS found a notice non-compliant 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 non-compliant if required fields were out of order or omitted.

4.2.1.2 Results

CMS found that, of the notices reviewed, approximately 77% used the correct attachment and standard format for their plan status. **Table 17** lists findings and observations related to this review area.

Table 17. Notice Format and Content Findings and Observations

Type	Findings and Observations
Notice Format and Attachment Type	<ul style="list-style-type: none"> ▪ Issuers used incorrect templates for renewal or discontinuation notices for QHPs offered through the FFMs. ▪ Issuers did not use the fixed fields in the standard notice format appropriately (e.g., did not include certain required fields or omitted a required paragraph). ▪ Issuers sent multiple notices to enrollees with coverage offered through the FFMs using both standard and non-standard notices.
Notice Content	<ul style="list-style-type: none"> ▪ Issuers did not include metal level changes in notices or included metal level information in supplemental information, rather than the notice. ▪ Issuers did not specify APTC amounts for eligible consumers in notices.

CMS found that fewer issuers used the correct standard notice for their plan status in the PY 2016 notice review (77%) as compared to the PY 2015 notice review (85%). In addition, fewer issuers were compliant with the requirements regarding the inclusion of the APTC amount (72% in PY 2016 and 98% in PY 2015). However, in both review years, most notices included the premium amount, used plain language, and discussed the changes in coverage as required (over 95% in each area across both years).

4.2.2 Timeliness

Per the September 2, 2014 bulletin, issuers must provide written notices to consumers in a timely manner. For renewal notices, “timely” meant issuers provided notices to consumers before the first day of the OEP.³⁰

4.2.2.1 CMS Review Methodology

To test issuer compliance with these requirements, CMS reviewed documentation submitted by issuers that logged when the issuers generated and mailed renewal and discontinuation notices for coverage offered through the FFMs. 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

³⁰ For discontinuations, regulations require issuers to notify enrollees at least 90 calendar days before the date of coverage discontinuation. However, CMS guidance 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.

renewal and discontinuation notices compliant if issuers sent them before the 2016 OEP began on November 1, 2015.

4.2.2.2 Results

Results showed that issuers sent notices in advance of the PY 2016 OEP 96% of the time. Generally, issuers sent notices about two weeks before the PY 2016 OEP began. **Table 18** lists findings and observations related to this review area.

Table 18. Notice Timeliness Findings and Observations

Type	Findings and Observations
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 2016 notice review were consistent with the PY 2015 notice review (96% in PY 2016 and 95% in PY 2015).

4.2.3 Notice Recipient

As explained in the September 2, 2014 bulletin, under federal regulations, an issuer that discontinues or renews a particular product must send written notices to all plan enrollees.³¹

4.2.3.1 CMS Review Methodology

To evaluate compliance with this requirement, CMS compared the names of notice recipients against CMS records for each recipient’s subscriber ID.

4.2.3.2 Results

Almost all the notices CMS sampled (99%) included names that matched the enrollee names in CMS records. **Table 19** lists findings and observations related to this review area.

Table 19. Notice Recipient Findings and Observations

Type	Findings and Observations
Validating Accuracy	<ul style="list-style-type: none"> Some issuers sent notices with names that did not match CMS’ records (e.g., first and last name of the recipient were displayed in reverse order, name was misspelled). One notice included extraneous pages from a notice to another subscriber.

The results in the notice recipient area were consistent with the PY 2015 notice review (99% in PY 2016 and 99% in PY 2015).

³¹ An important factor of evaluating compliance with this requirement is the assurance that issuers sent the correct notice to each recipient (i.e., addressed the notice to the correct individual and containing that individual’s information only). While the regulations and guidance bulletins do not explicitly state this requirement, CMS included it in the review as a “common sense” component.

4.2.4 Deductible and MOOP

Per the September 4, 2014 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 examples in the bulletin includes “cost sharing.” Therefore, CMS selected MOOP as a critical element 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.

4.2.4.1 CMS Review Methodology

CMS reviewed 119 notices affected by a MOOP change and 83 notices affected by a deductible change. 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.

4.2.4.2 Results

In the PY 2016 notice review, CMS found issuers communicated a correct change in MOOP about 60% of the time, while issuers communicated a correct change in deductible about 50% of the time. **Table 20** lists findings and observations related to this review area.

Table 20. Notice Deductible and MOOP Findings and Observations

Type	Findings and Observations
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 communicate a change in MOOP or deductible for enrollees affected by MOOP or deductible changes.

The results of communicating a correct change in MOOP were similar to the PY 2015 notice review (63% in PY 2016 and 56% in PY 2015). The results of communicating a correct change in deductible were consistent with the PY 2015 notice review (about 50% in both years).

4.2.5 Benefit Cost Structure and Cost-Sharing Changes

Per the September 2, 2014 bulletin, issuers must notify enrollees of significant changes in coverage.³²

³² Per the September 2, 2014 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.”

4.2.5.1 CMS Review Methodology

To evaluate compliance with this requirement, CMS reviewed both notices and supplemental documents, including a subset of 129 notices from 7 issuers (reflecting 12 QHPs). CMS conducted this in-depth review to determine whether issuers communicated changes in benefit cost structure and cost-sharing amounts for the following eight benefit categories: inpatient and hospital services, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.³³

- **Cost structure changes:** Consumer benefits are newly subject to (or no longer subject to) a deductible, copay, or coinsurance, or switch between copay and coinsurance.
- **Cost-sharing amount changes:** Consumers are subject to changes in the copay or coinsurance amount for each benefit.

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

4.2.5.2 Results

The results of the PY 2016 notice review showed that issuers did not always communicate cost structure changes in renewal notices to enrollees. None of the notices CMS reviewed for benefits information included information on five of the eight areas: emergency services, primary care, specialist, specialty drugs, and generic drugs.

The findings and observations in this area suggest a difference between issuers’ and CMS’ interpretations of the types of “significant changes to coverage” that should be included in the notices.

Table 21 lists findings and observations related to this review area.

Table 21. Benefit Cost Structure and Cost-Sharing Changes Findings and Observations

Type	Findings and Observations
Validating Accuracy	<ul style="list-style-type: none"> ▪ Issuers provided enrollees with a cost-sharing amount that matched CMS’ records (i.e., the amount presumed to be correct) about half of the time.
Communication	<ul style="list-style-type: none"> ▪ Issuers did not always notify affected enrollees of benefit cost-sharing or cost structure changes (e.g., enrollee was no longer subject to a copay for a certain benefit area). ▪ Some issuers included links in notices that routed to generic websites, not the location of the enrollee’s specific plan information.

CMS found the notices it reviewed in the PY 2016 notice review included information on changes to benefit cost structure (15% in PY 2016 and 46% in PY 2015) and cost-sharing amounts (34% in PY 2016 and 51% in PY 2015) less often than the notices reviewed in the PY 2015 notice review.

³³ CMS chose the eight selected benefit areas as a reasonable representation of “significant changes to coverage” in the context of the September 2, 2014 bulletin, page 6: “The following is considered by CMS to be the essential content contained in the form of the Federal standard renewal notices attached to this bulletin: Information about significant changes to the enrollee’s coverage...”

Appendix A: Program Areas and Standards Reviewed in 2015

Table 22 contains a consolidated list of regulatory standards for compliance reviews by review area. **Table 23** provides a list of the standards for each review area covered in notice reviews.

Table 22. Standards Applicable to Each Review Area for 2015 Compliance Reviews³⁴

Review Area	Standard
Agent and Broker Oversight	45 CFR 156.340(a)(3) – QHP issuer must ensure compliance by its affiliated agents/brokers, as downstream/delegated entities, in the following areas: 1) satisfying applicable FFM registration and training requirements, 2) maintaining licensure and good standing in each state in which the agent/broker operates, 3) executing the applicable FFM Privacy/Security Agreement(s) and (if applicable) the General Marketplace Agreement, and 4) use of the required disclaimers if an agent/broker uses a website other than Healthcare.gov to assist with QHP selection for enrollment through the FFM.
Casework	45 CFR 156.1010 (b) – QHP issuers operating in the FFMs must investigate and resolve, as appropriate, cases from the complainant forwarded to the issuer by HHS. Cases received by a QHP issuer operating in the FFMs directly from a complainant or the complainant's authorized representative will be handled by the issuer through its internal customer service process. 45 CFR 156.1010(d) – For cases forwarded by HHS, issuers in FFMs must resolve urgent cases no later than 72 hours after the case is received by the issuer, and non-urgent cases no later than 15 calendar days after the case is received by the issuer. 45 CFR 156.1010(f) – For cases forwarded by HHS, issuers must notify the complainant as soon as possible upon resolution of the case but no later than three business days after the case is resolved. 45 CFR 156.1010(g)(2) – For cases forwarded by HHS, issuers must document a resolution summary of the case no later than seven business days after resolution of the case.
Compliance Plans	45 CFR 156.715(a) – Issuers offering QHPs in the FFMs may be subject to compliance reviews to ensure ongoing compliance with FFM-specific standards applicable to issuers offering QHPs in the FFM. 45 CFR 156.715(b)(3) – In preparation for or in the course of the compliance review, a QHP issuer must make available for HHS to review the records of the issuer that pertain to its activities within the FFM. Such records may include, but are not limited to, any other information reasonably necessary for HHS to evaluate issuer compliance with QHP certification standards and other FFM-specific standards applicable to issuers offering QHPs in the FFM; evaluate the QHP's performance, including its adherence to an effective compliance plan, within the FFM; verify that issuers have performed the duties attested to as part of the QHP certification process; and assess the likelihood of fraud or abuse.
Delegated and Downstream Entities	45 CFR 156.340(a)(1) – A QHP issuer must ensure its delegated/downstream entities comply with the standards of 45 CFR Part 156, Subpart C, including the prohibition under 45 CFR 156.225(b) against employing marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. 45 CFR 156.340(b) – A QHP issuer must ensure that its delegation agreement(s) includes specified elements.
Enrollment Periods for Qualified Individuals	45 CFR 156.260(a) – A QHP issuer must enroll qualified individuals during the initial and subsequent annual Open Enrollment periods and allow for special enrollment periods (SEPs) in cases of specific triggering events. 45 CFR 156.260(b) – A QHP issuer must notify a qualified individual of his or her effective date of coverage.

³⁴ This table represents the regulations as applicable in 2015 when CMS conducted the reviews. Issuers should consult the CFR to determine current regulatory requirements.

Review Area	Standard
<p>Enrollment Process for Qualified Individuals</p>	<p>45 CFR 156.265 – A QHP issuer must adhere to the required enrollment processes for the individual market in compliance with 45 CFR 156.265.</p> <p>45 CFR 156.265(b) – A QHP issuer must enroll a consumer through the FFM only after the individual files an application with the FFM or receives an eligibility determination from the FFM.</p> <p>45 CFR 156.265(c) – A QHP issuer must accept enrollment information consistent with the privacy and security standards established by the Exchange applicable to safeguarding enrollment information with respect to personally identifiable information.</p> <p>45 CFR 156.265(d) – A QHP issuer must comply with rules regarding premium payments by individuals, Indian tribes, tribal organizations, and urban Indian organizations as well as premium payment rules regarding privacy and security.</p> <p>45 CFR 156.265(e) – A QHP issuer must provide new enrollees an enrollment information package that is compliant with accessibility and readability standards established in 155.230(b).</p> <p>45 CFR 156.265 (f) – A QHP issuer must reconcile enrollment files with the FFM not less than once a month.</p> <p>45 CFR 156.1250 – A QHP issuer must accept premium and cost-sharing payments from the third-party entities listed under 45 CFR 156.1250(a), (b), and (c) on behalf of plan enrollees.</p>
<p>Health Plan Applications and Notices (Meaningful Access)</p>	<p>45 CFR 156.250 – A QHP issuer must ensure the accessibility of Health Plan Application and Notices by making these documents accessible for individuals in accordance with the ADA and for individuals with limited English proficiency.</p>
<p>Maintenance of Records</p>	<p>45 CFR 156.705(a)(1) – Issuers offering QHPs in an FFM must maintain all documents and records necessary for HHS to periodically audit financial records related to QHP issuers' participation in the FFMs, and evaluate the ability of QHP issuers to bear the risk of potential financial losses.</p> <p>45 CFR 156.705(c) – Issuers must maintain the identified FFM records for 10 years.</p>
<p>Marketing and Benefit Design</p>	<p>45 CFR 156.225(b) – A QHP issuer must not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.</p>
<p>Network Adequacy</p>	<p>45 CFR 156.230(a) – A QHP issuer that uses a provider network must ensure its provider network includes ECPs in accordance with §156.235; sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that services will be accessible without unreasonable delay; and consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act (42 U.S.C. 300gg-1(c)).</p> <p>45 CFR 156.230(b) – A QHP issuer must make a provider directory for a QHP available to the FFM for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.</p> <p>45 CFR 156.235(a) – A QHP issuer that uses a provider network must have a provider network with a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the FFM network adequacy standards and the 2015 Letter to Issuers in the Federally-facilitated Marketplaces, Section 4: Essential Community Providers.</p>

Review Area	Standard
<p>Prescription Drug Formulary</p>	<p>45 CFR 156.122(a) – A health plan does not provide essential health benefits (EHB)³⁵ unless it covers at least the greater of: one drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB benchmark plan; and must submit its drug list to the Marketplace, the State, or OPM.</p> <p>45 CFR 156.122(c) – A health plan providing essential health benefits must have procedures in place that allow an enrollee, the enrollee’s designee, or prescribing provider (or other prescriber) to request and gain access to clinically appropriate drugs not covered by the health plan.</p>
<p>QHP Issuer Participation General Standards</p>	<p>45 CFR 156.200(a) – To participate in an FFM, a health insurance issuer must have a certification issued or recognized by the FFM to demonstrate that each health plan it offers on the FFM is a QHP.</p> <p>45 CFR 156.200(b)(2) – A QHP issuer must comply with FFM processes, procedures, and requirements under Subpart K of Part 155 and, in the small group market, 45 CFR 155.705.</p> <p>45 CFR 156.200(c) – A QHP issuer must offer at least one Gold and one Silver plan in the FFM, and child-only coverage options for each non-catastrophic QHP in the individual market.</p> <p>45 CFR 156.200(e) – A QHP issuer must not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation.</p> <p>45 CFR 156.200(f) – A QHP issuer must pay the same broker compensation for QHPs offered through a FFM that it pays for similar health plans offered in the State outside the FFMs.</p> <p>45 CFR 156.200(g) – A QHP issuer must comply with FF-SHOP participation provisions.</p>
<p>Rating Variations</p>	<p>45 CFR 156.255(b) – A QHP issuer must charge the same premium rate without regard to whether the plan is offered through a FFM, directly from the issuer, or through an agent.</p> <p>45 CFR 156.210(c) – A QHP issuer must submit to the FFM a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.</p>
<p>SHOP Marketplace</p>	<p>45 CFR 156.285(a) through (d) – Issuers must follow additional standards outlined in 45 CFR 156.285 specific to FF-SHOP including adhering to termination of coverage processes in the FF-SHOP Marketplace. The issuer must notify the qualified employer and the enrollee of a termination when the issuer terminates coverage or enrollment in accordance with 45 CFR 155.735(d)(1)(iii) or (v) and the notice must include the termination effective date and the reason for termination, and must be sent within three business days if an electronic notice.</p>

³⁵ However, a health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in 45 CFR 156.280(d). See 45 CFR 156.122(b).

Review Area	Standard
Termination of Coverage for Qualified Individuals	<p>45 CFR 156.270(a) – A QHP issuer may only terminate enrollment in a QHP through an Exchange as permitted by the Exchange in accordance with 45 CFR 155.430(b).</p> <p>45 CFR 156.270(b) – If a QHP issuer terminates an enrollee's coverage or enrollment in a QHP through an Exchange in accordance with §155.430(b)(2)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination.</p> <p>45 CFR 156.270(c) – A QHP issuer must establish a standard policy for handling terminations of enrollment of enrollees through the Exchange due to nonpayment of premiums as permitted by the Exchange in 45 CFR 155.430(b)(2)(ii).</p> <p>45 CFR 156.270(d) – A QHP issuer must provide a grace period of three consecutive months if an enrollee is receiving advance payments of the premium tax credit.</p> <p>45 CFR 156.270(e) – For the three-month grace period described in paragraph (d) of this section, a QHP issuer must follow applicable requirements related to the collection and return of advance payments of the premium tax credit on behalf of enrollees who are in the three-month grace period.</p> <p>45 CFR 156.270(f) – A QHP issuer must provide payment delinquency notices to affected enrollees.</p> <p>45 CFR 156.270(g) – A QHP issuer must follow applicable requirements if an enrollee receiving advance payments of the premium tax credit exhausts the three-month grace period.</p> <p>45 CFR 156.270(h) – A QHP issuer must maintain termination of coverage records in accordance with FFM-specific standards.</p> <p>45 CFR 156.270(i) – A QHP issuer must comply with the FFM rules for effective dates of termination of coverage.</p> <p>45 CFR 156.290(b) – If a QHP issuer elects not to seek recertification with the FFM for its QHP, the QHP issuer must provide written notice to each enrollee (i.e., a notice of QHP non-renewal).</p>

Table 23. Areas of Focus for Renewal and Discontinuation Notice Reviews

Focus Area	Standards Used by Reviewers
Notice Format and Content	CMS Bulletin (September 2, 2014) – Notice of discontinuations and renewals is consistent with the federal standard notice exhibits and requirements (excluding student health insurance plans).
Timeliness	45 CFR 156.1255 and 45 CFR 147.106(c) and (f); CMS Bulletin September 2, 2014 – Discontinuation or renewal notice was sent before November 1, 2015. ³⁶
Notice Recipient	45 CFR 156.1255 and 45 CFR 147.106(c)(1); CMS Bulletin September 2, 2014; and General Guidance – Notice was sent to the correct consumer (ensuring consumers in a continuing plan received a renewal notice, and consumers in a plan under a product that was not going to be available in the market in 2016 received a discontinuation notice). Notice was sent to a current 2015 enrollee of the QHP referred to in the notice. Notice referred to the correct coverage type (individual versus family).
Deductible and MOOP	CMS Bulletin (September 2, 2014) – Notice or supporting documentation communicates the changes in the consumer's coverage, including deductible, MOOP, and changes in benefit cost-sharing amounts and structure.
Benefit Cost Structure and Cost-Sharing Changes	CMS Bulletin (June 12, 2015) – APTC and CSR information was included in notice for eligible consumers.

³⁶ For discontinuations, regulations require issuers to notify enrollees at least 90 calendar days before the date of coverage discontinuation. However, CMS guidance 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.

Appendix B: Additional Information on Compliance Review Results

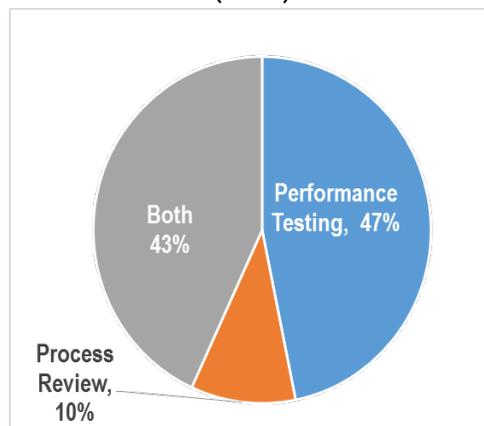
B.1 Agent and Broker Oversight

Figure 5 displays the percentage of issuers whose findings and observations in the agent and broker oversight review area were based on only process review, only performance testing, or both. Thirty issuers, out of the thirty-two issuers CMS reviewed, had one or more findings and observations in this review area, which amounted to forty-seven findings and observations. Out of these 47 findings and observations, 27 were based on performance testing and 20 were based on process review.

As shown in **Figure 5** 47% of these issuers (i.e., 14 of 30 issuers) had findings and observations based on performance testing of agent/broker NPNs. Under the performance testing, CMS’ comparison of NPNs against the Agent and Broker FFM Registration Completion List revealed that provider NPNs often did not match CMS’ records. Further validation revealed that, in some cases, agents and brokers received compensation even though the issuer had not verified whether they had completed the applicable FFM registration requirements. In other cases, agents and brokers received compensation and facilitated enrollments prior to issuers verifying completion of FFM training and registration requirements.

Ten percent of issuers (i.e., three of the thirty issuers that had one or more findings and observations in this review area) had just process review findings and observations, and forty-three percent of issuers (i.e., thirteen of these thirty issuers) had both process review and performance testing findings and observations. Process review findings and observations included agent and broker oversight policies that did not contain validation of completion of applicable agent and broker FFM training or were not in effect for all of PY 2015, and agent and broker agreement templates that did not contain the required FFM-specific language for the full plan year.

Figure 5. Issuers with Agent and Broker Findings and Observations, by Review Methodology (n = 30)



B.2 Casework

Figure 6 displays the percentage of issuers whose findings and observations in the casework review area were based on only performance testing or on both performance testing and process review. Twenty-seven issuers, out of the thirty-two issuers CMS reviewed, had one or more findings and observations in this review area. Out of 44 total findings and observations, 29 were based on performance testing and 15 were based on process review.

As shown in **Figure 6**, 44% of these issuers (i.e., 12 of 27 issuers) with findings and observations based on performance testing (new in 2015) had casework documentation that did not comply with the FFM casework resolution and/or notification requirements. For example, several issuers needed more than the 15 calendar days to resolve non-urgent cases and, for some cases reviewed, enrollees did not receive notification within the required 3 business days of case resolution.

Fifty-six percent of issuers that had one or more findings and observations in this review area (i.e., fifteen of the twenty-seven issuers) had both process review and performance testing findings and observations. Process review findings and observations included inadequate or incomplete policies to ensure compliance with HICS reporting, resolution, complainant notification, and/or resolution summary requirements; casework policies that were not in effect for the entire plan year; and lack of formal casework policies.

B.3 Compliance Plans

Figure 7 displays the percentage of issuers whose observations in the compliance plan review area resulted from process review. Ten issuers, out of the thirty-two issuers CMS reviewed, had observations in this review area. All of the 10 total observations in this area were based on process review.

Process review observations included incomplete policies (e.g., incomplete policy to review and update compliance plan) or compliance plans with no effective date, meaning CMS could not verify the plans to be in effect for all of PY 2015.

Figure 6. Issuers with Casework Findings and Observations, by Review Methodology (n = 27)

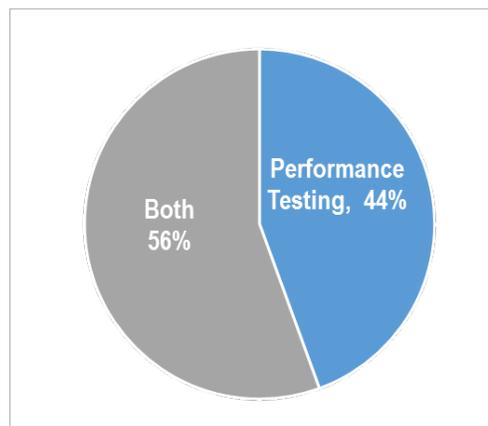
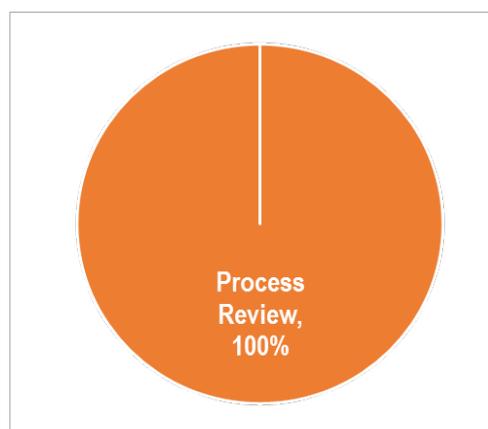


Figure 7. Issuers with Compliance Plan Observations, by Review Methodology (n = 10)



B.4 Delegated and Downstream Entities

Figure 8 displays the percentage of issuers whose findings and observations in the delegated and downstream entities review area were based on performance testing or on both performance testing and process review. Twenty-six issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area, which amounted to forty findings and observations. Out of these 40 findings and observations, 26 were based on performance testing and 14 were based on process review.

Forty-six percent of these issuers (i.e., twelve of twenty-six issuers) had findings and observations based on performance testing of delegation agreements/amendments. Specifically, issuers' executed delegation agreements/amendments did not include all or part of the required FFM-specific language.

Fifty-four percent of issuers (i.e., fourteen of twenty-six issuers that had findings and observations in this review area) had both process review and performance testing findings and observations. Process review findings and observations included incomplete policies, such as delegated entity oversight policies that did not include FFM-specific language, or issuers not having delegated entity oversight policies at all. Additional findings and observations included delegated entity oversight policies that were not in effect for the entire plan year, and that some issuers had no formal policy or procedure for oversight of delegated or downstream entities.

B.5 Enrollment Periods for Qualified Individuals

Figure 9 displays the percentage of issuers whose findings and observations in the enrollment periods for qualified individuals review area resulted from process review. Nineteen issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area.

Process review findings and observations included issuers that had incomplete policies (e.g., enrollment policy did not include a complete list of SEP-triggering events, enrollment policy did not include some or all of the FFM enrollment specifics). In addition, several issuers did not have policies that included an explanation of the special effective dates for SEPs based on marriage, birth, adoption, placement in foster care, or loss of minimum essential coverage.

Other findings and observations included that some issuers had no formal policy or procedure that defined annual OEP and/or SEPs, and effective dates of coverage. Finally, some issuers did not have policies in effect for the full plan year.

Figure 8. Issuers with Delegated and Downstream Entity Findings and Observations, by Review Methodology (n = 26)

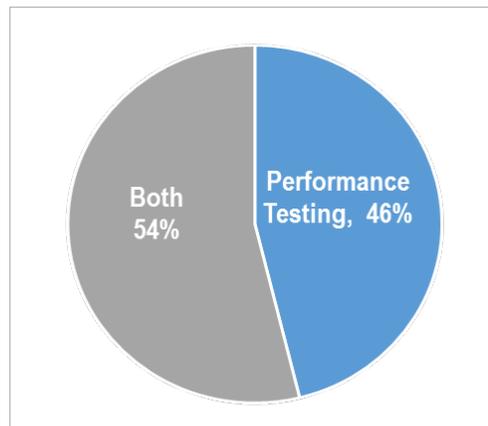
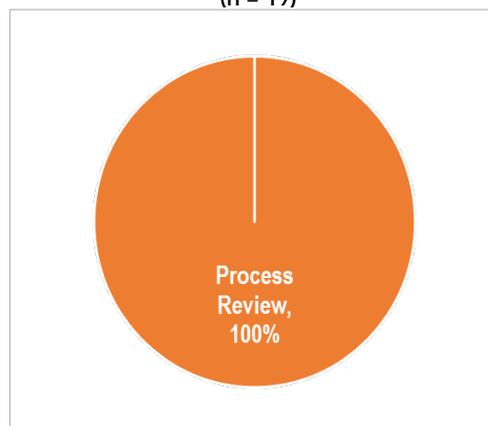


Figure 9. Issuers with Enrollment Period Findings and Observations, by Review Methodology (n = 19)



B.6 Enrollment Process for Qualified Individuals

Figure 10 displays the percentage of issuers whose findings and observations in the enrollment process for qualified individuals review area resulted from process review. Fifteen issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area.

All 27 findings and observations in this area were based on process review. Process review findings and observations included policies for enrollment eligibility, enrollment, premium payment, and data breach protection that were not in effect for all of PY 2015. Often, these issuers did not develop, approve, or finalize the policies until after the plan year had begun, or issuers revised the policies mid-plan year to include FFM requirements.

In addition, some issuers did not have formal policies in the areas described above, including policies for acceptance of third-party premium payments. Other issuers had incomplete policies related to enrollment processes. There were several findings and observations related to privacy and security; specifically, issuers' existing policies did not include FFM reporting requirements and reporting timeframes in the event of a security breach, or information about handling PII from FFM enrollees.

B.7 Health Plan Applications and Notices (Meaningful Access)

Figure 11 displays the percentage of issuers whose findings and observations in the health plan application and notices (meaningful access) review area were based on performance testing. Twenty issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area.

All 20 findings and observations were based on performance testing of required language taglines. Issuers sent notices to enrollees without required taglines for individuals with disabilities and/or limited English proficiency. The types of notices missing required taglines included enrollment letters, welcome packets, termination notices, HICS letters, late premium payment notices, and dental plan and health plan notices of privacy practices.

Figure 10. Issuers with Enrollment Process Findings and Observations, by Review Methodology (n = 15)

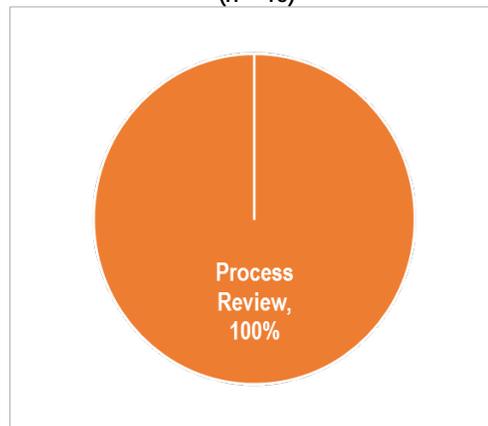
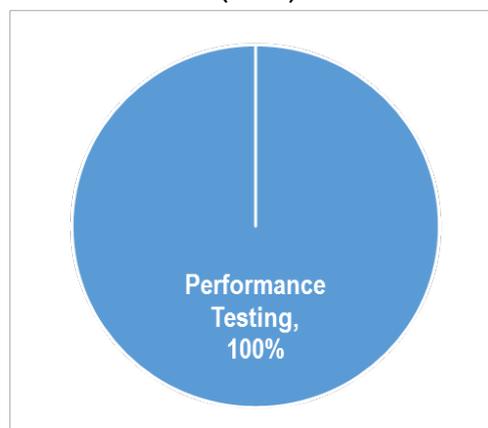


Figure 11. Issuers with Health Plan Applications and Notices Findings and Observations, by Review Methodology (n = 20)

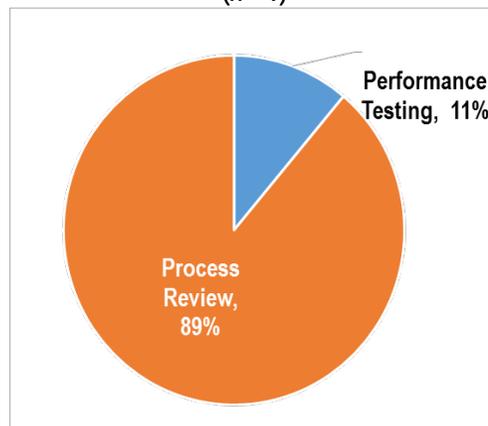


B.8 Maintenance of Records

Figure 12 displays the percentage of issuers whose findings and observations in the maintenance of records review area were based on only process review or only performance testing. Nine issuers, out of the thirty-two issuers CMS reviewed, had findings and observations related to maintenance of records. Out of nine total findings and observations in this area, one finding and observation was based on performance testing³⁷ and eight were based on process review.

Eighty-nine percent of these issuers (i.e., eight of nine issuers) had incomplete policies (e.g., record maintenance policy that did not include the ten-year record maintenance requirement or contained no effective date). One issuer did not have a record maintenance policy in effect for the entire plan year.

Figure 12. Issuers with Maintenance of Records Findings and Observations, by Review Methodology (n = 9)

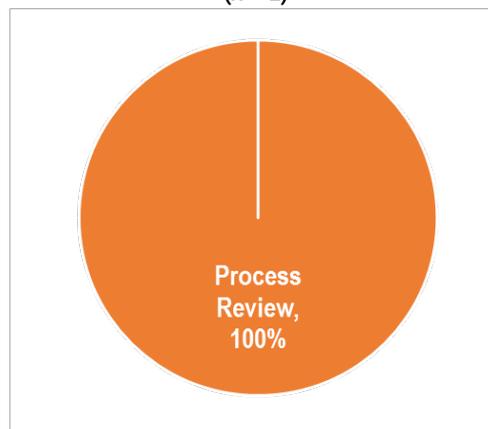


B.9 Marketing and Benefit Design

Figure 13 displays the percentage of issuers whose findings and observations in the marketing and benefit design review area were based on process review. Two issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area.

Process review findings and observations included lack of policies in effect to prevent employing discriminatory practices in the development of plan benefits.

Figure 13. Issuers with Marketing and Benefit Design Findings and Observations, by Review Methodology (n = 2)



B.10 Network Adequacy

Figure 14 displays the percentage of issuers whose findings and observations in the network adequacy review area were based on process review, performance testing, or both. Twenty-five issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area, which amounted to fifty-five findings and observations. Out of these 55 findings and observations, 42 were based on performance testing and 13 were based on process review.

³⁷ This finding was identified during performance testing for another review area. This review area contained no dedicated performance testing, but failure to maintain records as required by 45 CFR 156.705 may be revealed when conducting performance testing designed to test other regulatory requirements (which is what happened in this case).

Forty-eight percent of these issuers (i.e., twelve of twenty-five issuers) had findings and observations based on performance testing. Some issuers did not meet all three ECP requirements; in several cases, issuers had not extended annual contract offers to all available Indian health care providers within their service areas and/or had not extended annual contract offers to at least one ECP in each available ECP category in each county in their service areas, where an ECP in that category is available.

Performance testing of provider directories also revealed that several provider directories did not include whether providers were accepting new patients or the provider directory was out-of-date (e.g., some sampled providers were no longer in practice, the directory contained incorrect contact information for providers, and/or providers did not accept the issuer’s insurance anymore).

CMS made several observations based on issuers’ GeoAccess® reports that revealed insufficient provider coverage in several specialty areas.³⁸

For the 12% of these issuers (i.e., 3 of 25 issuers) with just process review findings and observations, some issuers did not have procedures for provider directory maintenance in effect for all of PY 2015 or a formal policy for provider directory maintenance. In addition, some issuers had incomplete policies (e.g., the issuer’s provider directory policy did not include a process to verify whether providers are accepting new patients, or did not include FFM requirements).

Forty percent of these issuers (ten of twenty-five issuers) had both process review and performance testing findings and observations.

B.11 Prescription Drug Formulary

Figure 15 displays the percentage of issuers whose findings and observations in the prescription drug formulary review area were based on only process review or only performance testing. Six issuers, out of the thirty-two issuers CMS reviewed, had findings and observations related to prescription drug formulary, which was a new review area in 2015. Out of the seven total findings and observations in this area, four were based on performance testing and three were based on process review.

For the 50% of these issuers (i.e., 3 of 6 issuers) with findings and observations based on performance testing,

Figure 14. Issuers with Network Adequacy Findings and Observations, by Review Methodology (n = 25)

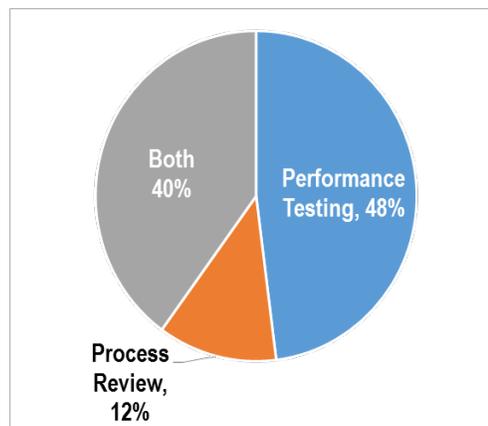
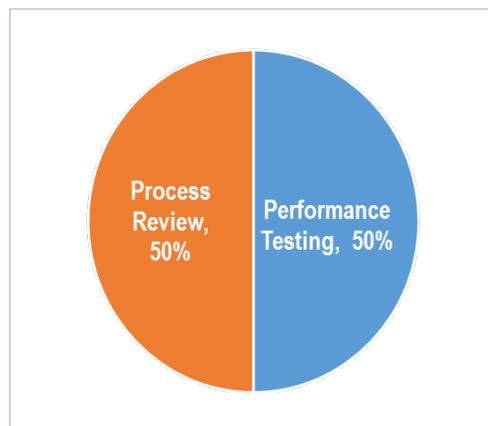


Figure 15. Issuers with Formulary Findings and Observations, by Review Methodology (n = 6)



³⁸ GeoAccess® is a tool to assess an issuer’s network adequacy based on distances between providers and consumers.

online formularies omitted drug restriction requirements. CMS also observed that some issuers had a significant number of changes to the formulary since certification (e.g., drugs identified as currently not covered when the template listed the drugs as covered) that may be prohibited by non-discrimination requirements specified at 45 CFR 156.125 and 156.225(b).

The remaining 50% of these issuers (i.e., 3 of 6 issuers) had process review findings and observations. Process review findings and observations included incomplete policies; specifically, drug tier information was inconsistent between issuers' policies and the formulary website for enrollees. In addition, some issuers did not have formulary policies in effect for the full plan year.

B.12 QHP Issuer Participation General Standards

Figure 16 displays the percentage of issuers whose findings and observations in the QHP issuer participation general standards review area were based on process review. Nine issuers, out of the thirty-two issuers CMS reviewed, had findings and observations in this review area, which amounted to eleven findings and observations.

All 11 findings and observations were based on process review. Process review findings and observations included incomplete non-discrimination policies (e.g., policies did not include protected class requirements, specifically, gender and race). CMS also documented findings and observations related to agent and broker compensation; in a few cases, issuers had different compensation rates for agents and brokers for products sold on versus off the FFMs.

In addition, some issuers did not have non-discrimination policies in effect for the duration of PY 2015, and did not have a formal non-discrimination policy.

B.13 Rating Variations

Figure 17 displays the percentage of issuers whose findings and observations in the rating variation review area were based on process review, performance testing, or both. Eight issuers, out of the thirty-two issuers CMS reviewed, had findings and observations related to rating variations, which amounted to nine findings and observations. Out of these nine findings and observations, five were based on performance testing and four were based on process review.

Fifty percent of these issuers (i.e., four of eight issuers) had findings and observations based on just performance testing (e.g., issuer did not post a premium rate justification on its website).

Figure 16. Issuers with Participation Standards Findings and Observations, by Review Methodology (n = 9)

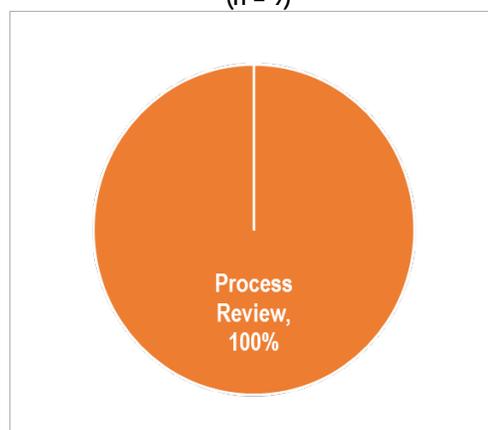
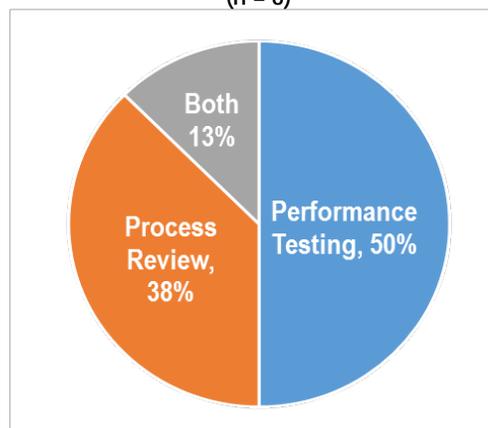


Figure 17. Issuers with Rating Variation Findings and Observations, by Review Methodology (n = 8)



Thirty-eight percent of these issuers (i.e., three of eight issuers) had process review findings and observations, and thirteen percent of these issuers (i.e., one of eight issuers) had both process review and performance testing findings and observations. Process review findings and observations included incomplete procedures for setting premium rates, and lack of procedures to post the justification of rate increases in effect for all of PY 2015.

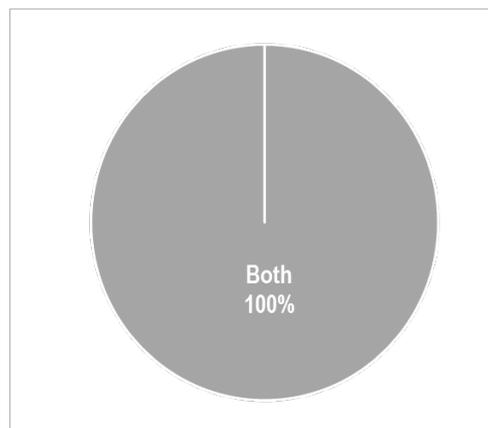
B.14 SHOP Marketplace

Figure 18 displays the percentage of issuers whose findings and observations in the FF-SHOP review area were based on both process review and performance testing. (Note that CMS only reviewed one FF-SHOP plan for one issuer.) Out of five total findings and observations, three were based on performance testing and two were based on process review.

Performance testing revealed that notices sent to FF-SHOP enrollees omitted required taglines for individuals with disabilities and/or limited English proficiency; NPNs for this issuer’s affiliated agents, brokers, or agencies that facilitated FF-SHOP enrollments did not match CMS records; and the issuer did not send FF-SHOP termination notices promptly.

Under process review, CMS found that some of the issuer’s SHOP enrollment or termination policies were not in effect for all of PY 2015.

Figure 18. Issuers with SHOP Findings and Observations, by Review Methodology (n = 1)

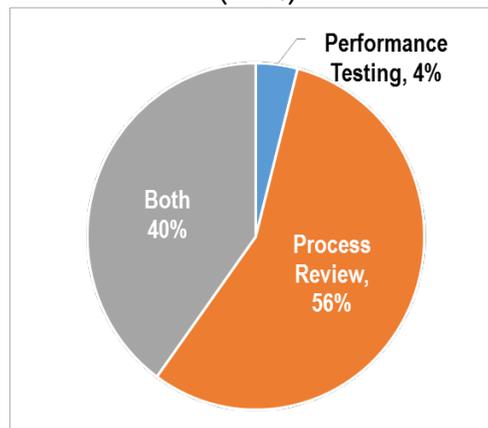


B.15 Termination of Coverage for Qualified Individuals

Figure 19 displays the percentage of issuers whose findings and observations in the termination of coverage for qualified individuals review area were based on only process review, only performance testing, or both. Twenty-five issuers, out of the thirty-two issuers CMS reviewed, had findings and observations related to termination of coverage, which amounted to forty-four findings and observations. Out of these 44 findings and observations, 11 were based on performance testing and 33 were based on process review.

As shown in **Figure 19**, 56% of these issuers (i.e., 14 of 25 issuers) had findings and observations based on just process review. Process review findings included incomplete termination policies (e.g., the policy did not include required language on all circumstances for termination), policies that did not include the FFM termination record maintenance requirement, and termination policies that omitted termination for fraud. In addition, some issuers did not have policies (e.g., termination or discontinuation policies) in effect for the entire plan year, or had no formal policy for non-recertification of a QHP or no formal policy to ensure termination of coverage requirements.

Figure 19. Issuers with Termination of Coverage Findings and Observations, by Review Methodology (n = 25)



Forty percent of issuers (i.e., ten of twenty-five issuers that had findings in this review area) had both process review and performance testing findings and observations and four percent of issuers (i.e., one of twenty-five issuers that had findings in this review area) had findings and observations based on performance testing. For performance testing, common findings and observations included termination notices that omitted the reason for termination, or that issuers did not send notices promptly.

Appendix C: Additional Information on Notice Review Results

C.1 Notice Format and Content

Figure 20 displays the overall findings and observations related to notice format and content.

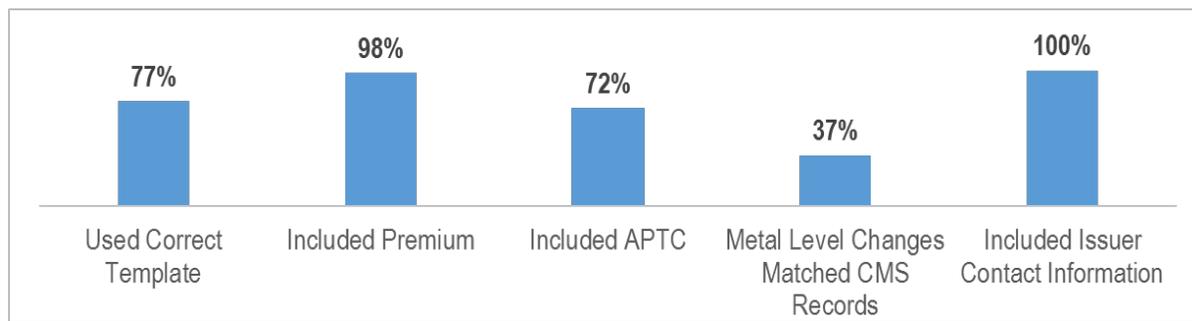
Results showed 77% of the notices CMS reviewed (i.e., 776 of 1,012 notices reviewed) used the correct template in accordance with CMS guidance. Most issuers that did not use the correct template sent a notice for “renewal in a new product” when they should have used the standard notice for “renewal in a different plan under the same product.”

Additionally, 98% of consumer notices or supplemental materials reviewed included premium amounts, and 72% included APTC amounts for eligible consumers.³⁹

Of the 348 notices that should have contained information about metal level changes, 37% (128 notices) did so. The information in these notices matched CMS’ records (i.e., they provided accurate information regarding the change in the enrollee’s metal level). While some notices communicated the metal level information in supplemental materials, not the notice itself, most issuers omitted this information from notices entirely.⁴⁰

Finally, all of the notices reviewed included issuer contact information. This information is key, should the consumer have a question or need to provide an update to the issuer.

Figure 20. Notice Format and Content



³⁹ CMS excluded consumers not enrolled into new plans from this analysis.

⁴⁰ CMS considered a notice compliant with the requirement to communicate metal level changes only if the issuer provided the information in the notice itself.

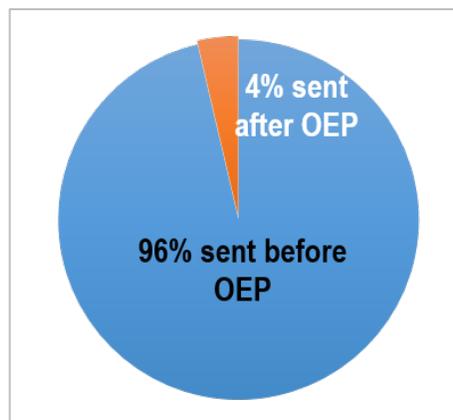
C.2 Timeliness

Figure 21 displays the percentage of issuers that sent both renewal and discontinuation notices before or after the PY 2016 OEP began.⁴¹ Out of the sample, 4% of notices were sent after the OEP began; these notices were sent an average of 28 days after the OEP began (i.e., around November 28, 2015).

For the 96% of notices sent before OEP, issuers sent notices 16 days before the OEP began, on average, or around October 16, 2015.

The average date on which issuers sent discontinuation notices was October 15, 2015 (i.e., 15 days before the OEP began). There was one late notice for plan discontinuation.

Figure 21. Timeliness of Notices
(n = 1,012)

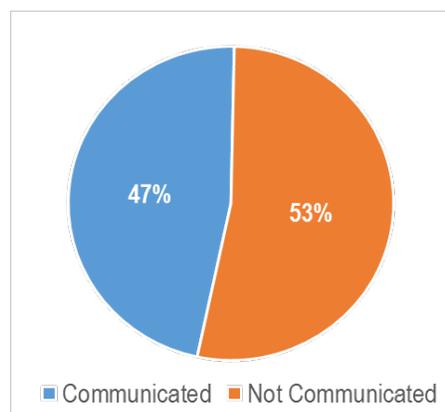


C.3 Deductible and MOOP

From a sample of 129 notices from 12 QHPs, CMS reviewed 83 notices for consumers affected by deductible changes. CMS found that 47% of the notices reviewed (i.e., 39 of 83 notices) communicated that the enrollee's deductible amount had changed and 53% of the notices reviewed (i.e., 44 of 83 notices) did not communicate this change. **Figure 22** displays the percent of issuers that communicated or did not communicate deductible changes to enrollees.⁴²

CMS found that 43 of the 83 notices reviewed for consumers affected by deductible changes were for plans with a separate medical and drug deductible. The remaining notices reviewed (i.e., 40 of 83 notices) were for plans that had an integrated deductible (i.e., a combined medical and drug deductible). Overall, deductible amount was communicated correctly in 48% (37) of notices affected by a deductible change.

Figure 22. Communication of Deductible Changes
(n = 83)

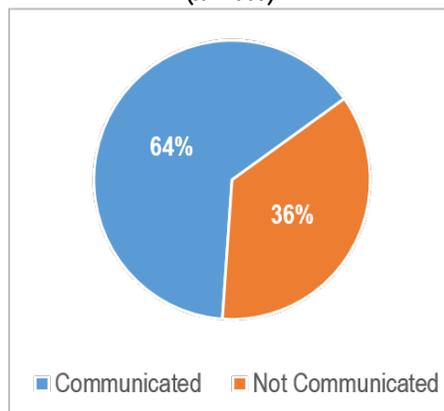


⁴¹ The OEP for PY 2016 began on November 1, 2015.

⁴² One issuer had non-compliance findings across all of its affected notices in the areas of correct communication of MOOP and deductible changes. Excluding this issuer, the compliance percentage would rise from 47% to 98% for deductible changes.

From a sample of 129 notices from 7 issuers across 12 QHPs, CMS reviewed 119 notices for consumers affected by MOOP changes. Sixty-four percent of enrollees (i.e., 76 of 119 enrollees) affected by MOOP changes were notified of the change and the remaining 36% of notices did not include required MOOP references. **Figure 23** displays the percentage of issuers that did or did not communicate MOOP changes.⁴³

Figure 23. Communication of MOOP Changes (n = 119)



All 119 affected notices had an integrated medical and drug MOOP. Issuers correctly communicated changes that matched CMS’ records in 63% of notices.

C.4 Benefit Cost Structure and Cost-Sharing Changes

CMS reviewed a subset of 129 notices from 7 issuers across 12 QHPs.

Table 24 displays the number of changes reviewed for both cost structure and cost sharing across the eight benefit areas that were part of this review. Some enrollees experienced no changes for a particular benefits area, while other enrollees may have experienced changes in multiple benefits areas or in multiple criteria within a single area.

Table 24. Changes Reviewed Across Benefit Areas

	Emergency and Hospital Care		Provider Visits		Prescription Benefits			
	Hospital	ER	Primary Care	Specialist	Generic	Non-Preferred	Preferred	Specialty
Cost Structure	0	86	36	36	9	131	131	56
Cost Sharing	86	208	140	165	129	111	111	129

⁴³ Excluding the one issuer that had non-compliance findings across all of its affected notices in the areas of correct communication of MOOP and deductible changes, the compliance percentage would rise from 64% to 100% for MOOP changes.

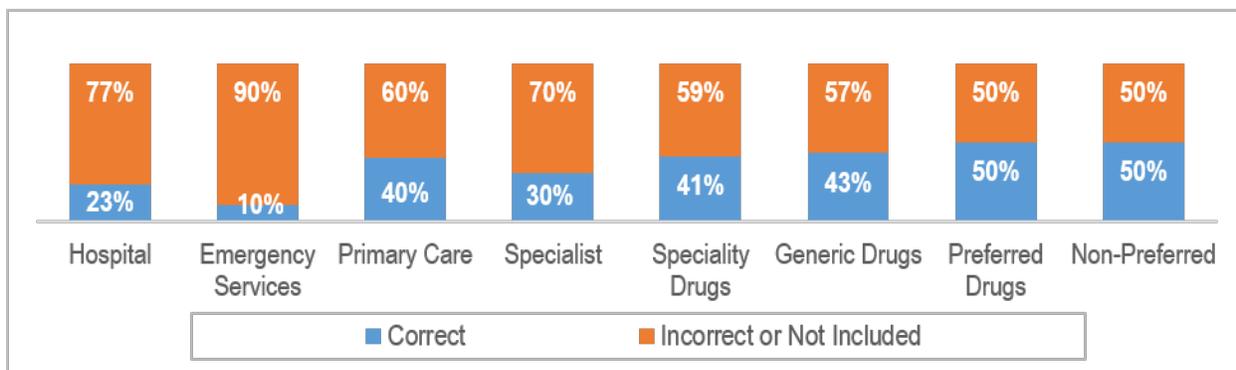
Figure 24 displays the percent of cost structure changes correctly communicated within affected notices across each benefit area that was part of the review. None of the issuers whose notices CMS reviewed notified affected enrollees of a benefit cost structure change in the following five benefit areas under review: emergency services, primary care, specialist visits, specialty drugs, and generic drugs. For the preferred drug and non-preferred drug benefit areas, issuers included structure changes 27% of the time.

Figure 24. Communication of Cost Structure Changes⁴⁴



Figure 25 displays the percentage of cost-sharing amount changes (e.g., copay or coinsurance amount) that were included and correct based on a comparison of issuer notices with CMS’ records. In comparison, the graph also displays when an amount was not included or did not match CMS’ records (i.e., was incorrect).

Figure 25. Communication of Cost-Sharing Amount Changes



⁴⁴ Figure 24 does not include a bar for “Hospital” because none of the reviewed notices was for a plan that had upcoming changes in cost structure for hospital benefits.