



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

**2018 Plan Year
Federally-Facilitated Exchange
Issuer Compliance Summary Report**

February 7, 2020

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

This report summarizes the results from FFE compliance review activities related to plans certified for Plan Year (PY) 2018.¹ By sharing this report, CMS can provide insights on identified areas of non-compliance in 2018 and help issuers ensure their processes, procedures, and activities comply with CMS regulations and guidance.

Per 45 CFR § 155.1010(a)(2) and § 156.715, CMS may conduct compliance reviews of issuers offering QHPs, including stand-alone dental plans (SADPs), in the FFEs to ensure ongoing compliance with QHP certification standards and FFE requirements. CMS selected 23 issuer identification numbers (IDs) from 16 FFE states² for compliance reviews of plans certified for PY 2018. These compliance reviews focused on issuer processes and operational testing related to the following areas: prescription drug benefits, QHP issuer participation standards, transparency in coverage, rate and benefits information, marketing and benefit design, provider directory quality, Essential Community Provider contracting (ECPs), meaningful access to health plan information, special enrollment period notices, enrollment processes for qualified individuals, termination of coverage for qualified individuals, issuer oversight of delegated and downstream entities including affiliated agents and brokers, health insurance casework system (HICS), rating variations, maintenance of records, and compliance plans.

The results from compliance reviews are categorized as “findings” or “observations.” Findings may result from discovery of evidence suggesting non-compliance, in addition to cases of confirmed non-compliance. Observations may result from identification of areas for improvement when there is no evidence of actual non-compliance.

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

¹ For the purposes of this report, CMS defines Plan Year 2018 as the period between January 1, 2018 and December 31, 2018.

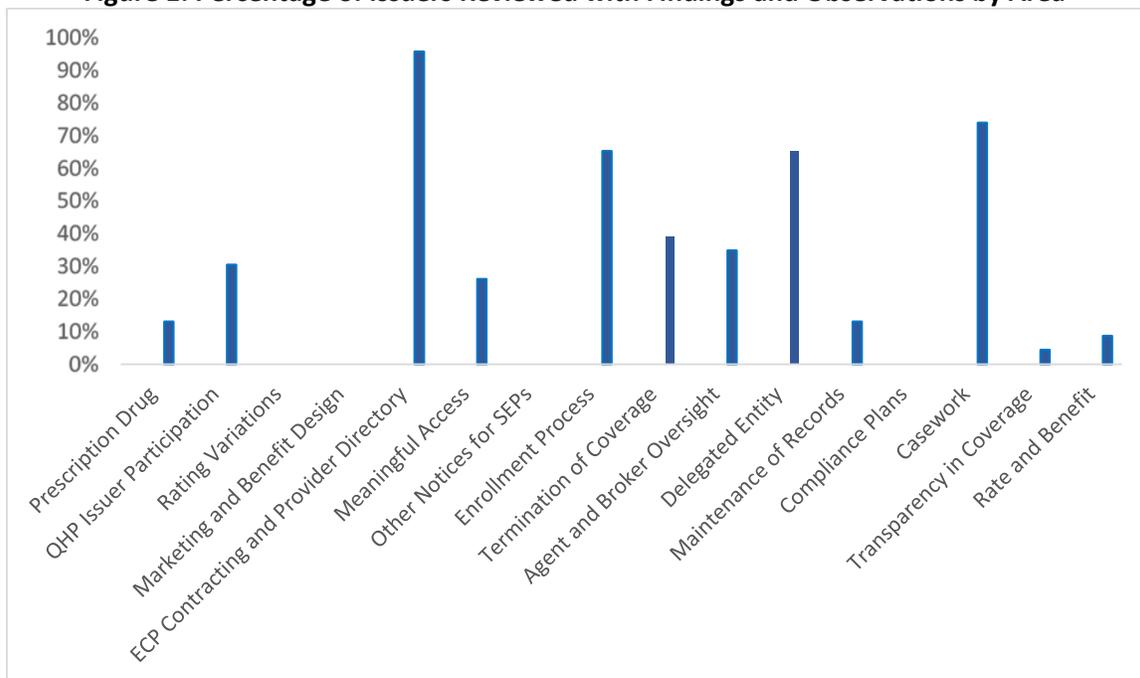
² The 16 FFE states were GA, IN, KS, ME, MI, MO, NC, ND, NE, OH, OK, PA, TN, TX, VA, and WI.

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

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

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

Figure 1: Percentage of Issuers Reviewed with Findings and Observations by Area³



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 Exchanges to ensure ongoing compliance with requirements for QHP certification under 45 CFR Part 156 and other FFE standards. FFE compliance reviews may help issuers identify opportunities for improvement in meeting regulatory requirements and assist CMS in determining where additional guidance may be helpful. This section provides an overview of the compliance review process. A visual representation of the steps in the FFE compliance review process is depicted in Figure 2. CMS also released guidance in the form of the *Key Priorities for FFE Compliance Reviews for the 2018 Benefit Year*, which sets forth a list of regulatory standards that CMS planned to include in the PY 2018 compliance reviews. This document is available at:

<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Key-Priorities-FFM-2018.pdf>.

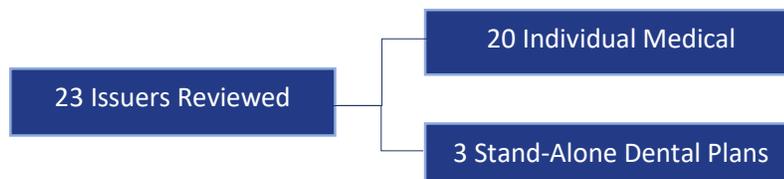
Figure 2: The FFE Compliance Review Process



³ Statistics represented have been determined by the number of findings or observations attributed to a particular review area. Scoring may represent multiple findings attributed to the same area, as seen under ECP Contracting and Provider Directory which includes findings or observations for both areas being tested under one combined heading.

CMS selects issuers for compliance reviews based on performance data and ongoing monitoring activities. For PY 2018, CMS conducted compliance reviews of 23 issuers. Beginning in March 2018, CMS issued notifications to the selected issuers and conducted kick-off calls to discuss each issuer's selection and the compliance review process, as well as to inform the issuer of any documentation needed prior to start of the reviews. After receiving and reviewing the requested documentation, CMS conducted interviews with each issuer's staff about its FFE operations. Figure 3 shows a breakdown of the issuer characteristics for PY 2018 compliance reviews.

Figure 3: Issuer Characteristics for PY 2018 Compliance Reviews



The PY 2018 compliance reviews consisted of 3 onsite reviews (encompassing 6 QHPs) and 17 desk reviews.⁴ During each review, CMS: 1) reviewed issuers' policies, procedures, and processes for all review areas within the scope of the review, and 2) performed testing for 13 of the 16 review areas to assess compliance with FFE-specific regulations.

The next section details the results of the PY 2018 compliance reviews by review area. The PY 2018 compliance reviews continued to focus more on issuers' processes and performance, and less on their written policies and procedures than prior years. Written policies and procedures were requested and reviewed as an aid for determining whether an issuer's processes complied with FFE requirements and to provide a basis for any recommendations.

3. COMPLIANCE REVIEW RESULTS

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

CMS classified findings and observations⁵ based on the type of review methodology⁶ employed:

⁴ CMS conducted onsite reviews at an issuer's facility when a parent company had centralized operations for multiple issuers in one location. For desk reviews, CMS used telephone interviews, webinars, and email to collect the necessary information and documents for review.

⁵ Review areas may contain findings, observations, or both, depending on testing results.

⁶ Information about the CMS Review Methodologies is a high-level summary of the review processes completed for each area under review. It is not expected that this information provides sufficient guidance to complete a similar review and necessarily arrive at the same conclusion.

- **Process Review:** This included review of issuers' written processes and procedures for review areas within the scope of the PY 2018 compliance reviews. Throughout the reviews, CMS requested and examined applicable policies and procedures established and provided by the issuers. This was completed primarily for informational purposes as most regulations do not require a written policy or procedure.
- **Performance Testing:** This included testing to assess issuers' compliance with FFE regulations for review areas within the scope of the PY 2018 compliance reviews. CMS completed testing using either 100% of available data (e.g., contracts, cases, notices) or a random sample of data. The decision of which sampling methodology to use was based on the test being performed.

Results by Review Area

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

3.1 Prescription Drug Formulary

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

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

3.1.1 CMS Review Methodology

CMS reviewed prescription drug formularies available on the issuers' websites against those submitted as part of the PY 2018 QHP application process to determine whether there were significant changes to the formularies since certification, which may be prohibited by non-discrimination requirements specified at 45 CFR § 156.125 and § 156.225(b). In addition, CMS reviewed the issuer's drug formularies to determine if the number of specific drugs available met minimum threshold requirements of 45 CFR § 156.122(a)(1) across a broad range of therapeutic classes and recommended drug treatment regimens. CMS also reviewed the issuers' exception request process to determine if the evaluation and notification process is completed in a manner consistent with the requirements of 45 CFR § 156.122(c).

3.1.2 Results

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

Table 1: Prescription Drug Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Drug exception request determinations and notifications were not completed or provided to patient or designee within required timeframes. ▪ Formulary did not provide complete prescription tier structure information.

3.1.3 *Best Practices*

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

3.2 QHP Issuer Participation General Standards

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

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

3.2.1 *CMS Review Methodology*

CMS reviewed non-discrimination policies to ensure that the policies were in place and available to employees and that the policy included all classes identified under the regulation. CMS also reviewed agent and broker compensation policies, comparing amounts paid for on- and off-Exchange coverage, subscriber agreements, and lists of the QHPs (by type) offered under the participating issuer IDs.

3.2.2 *Results*

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

Table 2: QHP Issuer Participation General Standards Findings or Observations

Review Methodology	Findings or Observations
Process Testing	<ul style="list-style-type: none"> ▪ Issuer’s policy or process documents did not include all protected classes such as race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

3.2.3 Best Practices

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

3.3 Rate and Benefit Information

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

3.3.1 CMS Review Methodology

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

3.3.2 Results

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

Table 3: Rates and Benefits Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did not post the justification for a premium rate increase on its website.

3.3.3 Best Practices

- Establish an annual process to ensure a justification is posted to the issuer’s website, consistent with FFE regulations.

3.4 Transparency in Coverage

Pursuant to 45 CFR § 156.220, QHP issuers must provide specific information in accordance with the regulation to the Exchange, the Department of Health and Human Services (HHS), and their State insurance commissioner, and make the information available to the general public, in plain language. QHP issuers also must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual through a website or other means for individuals without access to the internet.

3.4.1 *CMS Review Methodology*

CMS reviewed issuer websites to determine if the issuer provided links to required information, either on a single page or within multiple webpages that may be accessible from a landing page.

3.4.2 *Results*

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

Table 4: Transparency in Coverage Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did maintain an active URL; however, certain information required by the transparency-in-coverage regulations was not available within the links provided.

3.4.3 *Best Practices*

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

3.5 Marketing and Benefit Design

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

3.5.1 *CMS Review Methodology*

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

3.5.2 *Results*

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

Table 5: Marketing and Benefit Design Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ No findings or observations were identified in this review area.

3.5.3 *Best Practices*

- Establish and utilize a process that evaluates and monitors the design of each plan's benefits to ensure that plans are not designed with potentially discriminatory benefits or requirements.
- Establish and utilize a process that evaluates and monitors the marketing plan for each product to ensure that the marketing practices will not have the effect of discouraging the enrollment of individuals with significant health needs.

3.6 ECP Contracting and Provider Directory

Pursuant to 45 CFR § 156.230(a)(2), (a)(3), and (b), issuers with QHPs that use provider networks are required to maintain a sufficient provider network by:

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

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

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

3.6.1 CMS Review Methodology

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

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

CMS' testing of this review area also included a comparison of the QHPs' ECP lists against the *HHS 2018 Non-Exhaustive List of ECPs* to identify if there were any counties and/or specialties within the QHPs' service areas which did not meet the FFE requirements for ECPs. In those counties where QHPs did not meet ECP requirements, CMS requested documentation that the issuers had extended a good-faith offer to contract to all Indian health care providers within the QHPs' service areas and at least one ECP provider in each category in each county in the QHPs' service areas.

3.6.2 Results

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

Table 6: ECP Contracting and Provider Directory Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Provider directories did not indicate whether providers were accepting new patients, and/or were incorrect or out-of-date (e.g., some sampled providers were no longer in practice and/or had incorrect contact information). ▪ Issuer’s ECP list did not meet all ECP contract-offer requirements (e.g., some QHP issuers did not offer contracts to one or more Indian health care providers in their service area or could not provide documentation proving such contract offers were made).

3.6.1 Best Practices

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

3.7 Meaningful Access

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

3.7.1 CMS Review Methodology

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

3.7.2 Results

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

Table 7: Meaningful Access Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> Issuers sent various notices to enrollees (e.g., HICS resolution, enrollment letters, welcome packets) that omitted the required taglines for individuals with disabilities and/or limited English proficiency.

3.7.1 Best Practices

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

3.8 Premium Rate Variations

Pursuant to 45 CFR § 147.102(a) and 45 CFR § 156.255(b), QHP issuers are required to charge the same premium rate without regard to whether the plan is offered through an Exchange, directly from the issuer, or through an agent. Premium variations are not permitted on the basis of the method of sale or the offering of a plan through an Exchange.

3.8.1 CMS Review Methodology

CMS performed comparisons of the premiums for QHPs sold on- and off-Exchange to determine if the rates being charged were comparable⁷ for similar plans.

3.8.2 Results

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

Table 8: Premium Rate Variation Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> No findings or observations were identified related to this review area.

3.8.3 Best Practices

- Monitor pricing strategies and actuarial data across plans to ensure that QHPs will not have pricing differences related to being offered on Exchange or directly through the QHP Issuer.

⁷ The definition of “comparable” for this evaluation was determined to be a variance between similar QHP of less than one dollar per month.⁸ Available at <https://data.healthcare.gov/dataset/AB-Registration-Completion-List/wb6u-x2ny/data>.

3.9 Other Notices for Special Enrollment Periods for Qualified Individuals

Pursuant to 45 CFR § 156.1256, issuers must notify enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period within 30 calendar days of being notified by an FFE that the error has been fixed, if directed to do so by an FFE.

3.9.1 CMS Review Methodology

CMS reviewed certification records to determine if an issuer had been required to make a notification to its enrollees. If the issuer had been required to make the appropriate notifications, CMS selected a sample of impacted enrollees. The letters were reviewed to determine if they had been sent within the appropriate timeframes and that they used the approved notification template.

3.9.2 Results

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

Table 9: Other Notices for Special Enrollment Period Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ No findings or observations were identified related to this review area.

3.9.3 Best Practices

- Actively monitor plan submissions and plan displays to ensure that errors are not included.
- Should errors be identified, the issuer should actively review the errors and make all required notifications within timeframes required.

3.10 Enrollment Process for Qualified Individuals

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

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

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

3.10.1 CMS Review Methodology

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

3.10.2 Results

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

Table 10: Enrollment Process Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did not have a process for, was not aware of, or had not been compliant with the FFE incident or breach reporting requirements as required by section II.c.7 of the Qualified Health Plan Certification Agreement and Privacy and Security Agreement between Qualified Health Plan Issuer and the Centers for Medicare & Medicaid Services.

3.10.3 Best Practices

- Evaluate and update policies and procedures related to incident and breach reporting with respect to QHPs offered through the FFEs and include the required notification timeframes and a reporting process as appropriate.
- Evaluate and update notification processes to monitor all mailings and document the timeframes for them to be sent.
- Monitor all mailings to ensure that letters or notifications are sent to enrollees as required.

3.11 Termination of Coverage for Qualified Individuals

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

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

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

3.11.1 CMS Review Methodology

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

3.11.2 Results

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

Table 11: Termination of Coverage Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did not establish a standard written policy for the termination of enrollees due to non-payment of premiums. ▪ Issuer did not send termination notices to all enrollees or they were sent with undue delay. ▪ Termination notices did not include a reason for termination, an end date to the enrollees' coverage, or other required information.

3.11.3 Best Practices

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

3.12 Agent and Broker Oversight

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

- Satisfaction of applicable FFE registration and training requirements.

3.12.1 CMS Review Methodology

CMS reviewed issuers' written policies and procedures related to affiliated agent and broker onboarding. CMS then cross-referenced issuers' submitted lists of National Producer Numbers (NPNs) for affiliated agents and brokers who assisted with PY 2018 enrollments against the published *CMS Agent and Broker FFE Registration Completion List for Plan Year 2018*⁸ to determine if each agent or broker had completed the required FFE registration and training for PY 2018. CMS also compared the

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

registration completion dates of those registered agents or brokers with the date of the first enrollment they assisted with for PY 2018 to determine if the agents or brokers were assisting with enrollment prior to having completed the registration and training process.

3.12.2 Results

Table 12 lists findings or observations for this review area.

Table 12: Agent and Broker Oversight Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ NPNs for affiliated agents, brokers, or agencies did not match CMS' records, indicating that they had not completed the required registration and training process for PY 2018. ▪ Affiliated agents or brokers (including agent broker entities) did not complete the required FFE registration and training for PY 2018 prior to assisting individuals with enrollment in the FFEs.

3.12.3 Best Practices

- Regularly review CMS's agent and broker registration completion list and compare it with affiliated agents' and brokers' NPNs to ensure that agents and brokers have completed FFE registration, as required, if they are assisting consumers with FFE enrollments.
- Establish a process to educate affiliated agents and brokers found to be out of compliance with the FFE registration and training requirements.

3.13 Delegated and Downstream Entities

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

3.13.1 CMS Review Methodology

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

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

3.13.2 Results

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

Table 13: Delegated and Downstream Entity Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's downstream and delegated entity agreements (including any amendments thereto) did not include all of the language required by 45 CFR § 156.340.

3.13.3 Best Practices

- Review all contracts with downstream and delegated entities performing functions related to the FFEs to ensure that the language required under 45 CFR § 156.340 is incorporated (as applicable).
- Establish oversight processes for downstream and delegated entities to ensure they are in compliance with their contractual obligations and related FFE requirements.

3.14 Maintenance of Records

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

3.14.1 CMS Review Methodology

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

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

3.14.2 Results

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

Table 14: Maintenance of Records Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's record retention schedule and policy did not indicate a retention time frame of the require period. ▪ Issuer's records were not available when requested.

3.14.3 *Best Practices*

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

3.15 Compliance Plans

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

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

3.15.1 *CMS Review Methodology*

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

3.15.2 *Results*

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

Table 15: Compliance Plan Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ No findings or observations were identified related to this review area.

3.15.3 *Best Practices*

- Create and regularly evaluate the compliance plan to help demonstrate that the organization has established procedures consistent with 45 CFR 155.1000 (c), including an overall process of remaining compliant with each regulation as well as providing punitive and corrective actions should they be required.

3.16 Casework

Pursuant to 45 CFR § 156.1010, FFE issuers must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS⁹;
- 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;

⁹ CMS records casework in the Health Insurance Casework System (HICS), a web application that CMS requires issuers operating in FFEs to use for casework intake and resolution activities.

- Provide notice¹⁰ to the complainant of the disposition of a case as soon as possible upon resolution of the case, but in no event later than 3 business days after the case is resolved; and
- Record resolution summaries in the HICS within 7 days of completion with a clear and concise explanation of the how the case was resolved.

3.16.1 CMS Review Methodology

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

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

3.16.2 Results

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

Table 16: Casework Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer's cases were not closed or were not documented as such within the required timeframes as applicable based on whether they were non-urgent or urgent. ▪ Written notifications were not sent to consumers either within 3 business days or in a timely manner in cases where the initial notification was made verbally. ▪ Consumers were not notified of their case's resolutions.

3.16.3 Best Practices

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

4. CONCLUSION

FFE compliance reviews in PY 2018 were conducted for 23 FFE issuers representing 20 distinct parent companies in 16 FFE states. This included 20 individual medical issuers and 3 SADPs. Six of the reviews were completed onsite, and the remainder were completed through desk reviews.

¹⁰ To meet this requirement, notification may be verbal or written as determined most appropriate by the QHP issuer. In instances where notification is verbal, then a written notification must be provided in a timely manner to the consumer.

Review areas that frequently included findings or observations included:

- Ensuring accurate and up-to-date provider directory information as required by 45 CFR § 156.230(b)(2);
- Reviewing agreements with downstream and delegated entities to ensure their compliance with 45 CFR § 156.340(b);
- Completing HICS casework as required by 45 CFR § 156.1010, including recording outcomes and making appropriate notifications in a timely manner; and
- Notifying enrollees of their termination in a timely manner as required by 45 CFR § 156.270.

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2017 and 2018, CMS modified the compliance review process to further increase the focus on testing operations and data rather than reviewing documented procedures. CMS also refined existing methodologies to ensure the process continues to provide data about FFE issuer compliance while remaining efficient. The insights gained from FFE compliance reviews will continue to inform future guidance and regulatory updates.

5. APPENDIX – Finding or Observation Count by Review Area and De-Identified Issuer¹¹

Year ID	Agent and Broker Oversight	Casework	Delegated Entity	ECP Contracting and Provider Directory	Enrollment Process	Maintenance of Records	Meaningful Access	Prescription Drug	QHP Issuer Participation	Rate and Benefit	Termination of Coverage	Transparency of Coverage	Grand Total by Issuer
2018-01			1	1		1			1				4
2018-02	1	1	1	1	1								5
2018-03	1	1	1	1	1								5
2018-04			1		1								2
2018-05			1	2									3
2018-06			1	1	1								3
2018-07		1		1			1	1	1		1		6
2018-08	1	1		1	1				1	1	1		7
2018-09		1											1
2018-10		1	1	2	2	1			1	1			9
2018-11		1	1	1								1	4
2018-12		1		1	1	1	1		1		1		7
2018-13	1	2	1	1	1						1		7
2018-14		1											1
2018-15	1	1	1	1	1						1		6
2018-16	1	1	1	1	1		1				1		7
2018-17	1		1	1					1				4
2018-18		1	1	1	1			1					5
2018-19	1	1	1	2	1		1	1			1		9
2018-20				1	1						1		3
2018-21		1		1			1		1		1		5
2018-22		1											1
2018-23			1	1	1		1						4
Grand Total by Review Area	8	17	15	22	15	3	6	3	7	2	9	1	

¹¹ The appendix includes areas under review for which a finding or observation was identified; the remaining areas have been excluded for readability and space constraints.

The appendix above contains the actual count of each finding or observation recorded by review area and by de-identified issuer. The information in this chart represent only those review areas for which there was an identified finding or observation recorded for each issuer.