



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

**2020 Plan Year
Federally-Facilitated Exchange
Issuer Compliance Review Summary Report**

December 30, 2021

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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 QHP issuers are compliant with FFE standards. FFE compliance reviews also help QHP 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) 2020.¹ By sharing this report, CMS can provide insights on identified areas of noncompliance in 2020 and help QHP 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 QHP 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 22 QHP issuer identification numbers (IDs) from 16 FFE states² for compliance reviews of plans certified for PY 2020. These compliance reviews focused on QHP 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, network adequacy, special enrollment period notices, enrollment processes for qualified individuals (privacy and security policies), termination of coverage for qualified individuals, QHP issuer oversight of delegated and downstream entities including affiliated agents and brokers, health insurance casework system (HICS), rating variations, maintenance of records, patient safety standards, and compliance plans.

Due to the COVID-19 public health emergency (PHE)³, CMS modified the compliance review process for PY 2020. Of the 22 QHP issuer identification numbers selection, CMS conducted full compliance reviews of seven QHP issuers' identification numbers. The remaining 15 compliance reviews were conducted as modified compliance reviews. Please see Section 5: Modified Compliance Reviews for more information.

The results from compliance reviews are categorized as "findings" or "observations." Findings may result from discovery of evidence suggesting noncompliance, in addition to cases of confirmed noncompliance.

¹ For the purposes of this report, CMS defines Plan Year 2020 as the period between January 1, 2020, and December 31, 2020.

² The 16 FFE states were AK, AZ, DE, GA, IL, LA, ME, MI, MT, NC, OH, SD, TX, UT, VA, and WI.

³ On October 15, 2021, HHS Secretary Xavier Becerra, renewed, effective October 18, 2021, the determination that a public health emergency exists and has existed since January 27, 2020 as the result of the 2019 novel coronavirus, nationwide. See Renewal of Determination That A Public Health Emergency Exists, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVIDI-15Oct21.aspx>

Observations may result from identification of areas for improvement when there is no evidence of actual noncompliance.

The compliance reviews further divide results by methodology. Process findings or observations were primarily issues identified with a QHP issuer's underlying process to complete a required activity. Performance findings or observations were primarily included when a QHP 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 a QHP issuer having problems with both its process and performance of a required activity.

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

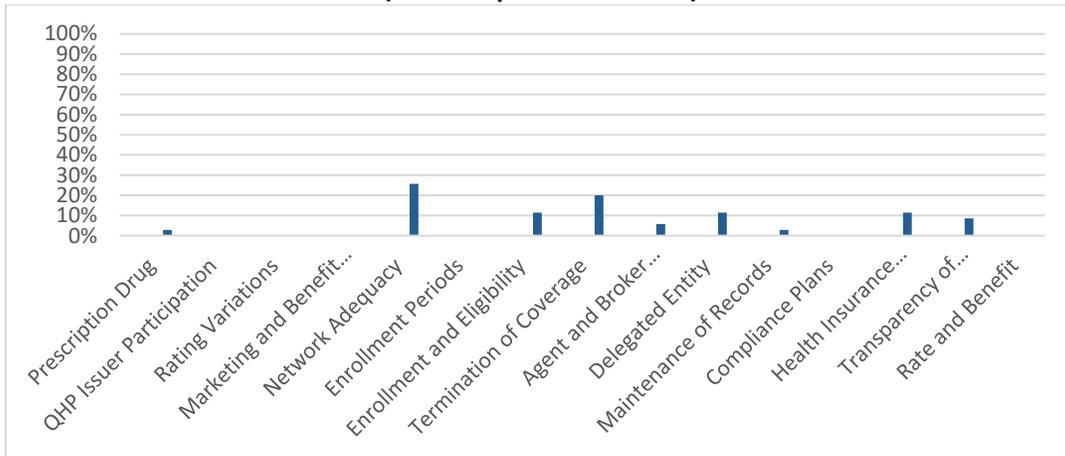
- Network Adequacy: CMS identified issues regarding network adequacy including: QHP issuers did not make contract offers to Essential Community Providers (ECPs) and Indian health care providers as required by 45 CFR § 156.235(a)(2)(ii); and provider directories or machine-readable data files that contained specific data elements were not up-to-date, complete, and accurate as required by 45 CFR § 156.230(b).
- Downstream and Delegated Entities^{*4}: CMS identified QHP issuer downstream and delegated entity contracts that did not include the Exchange-specific language required by 45 CFR § 156.340(b).
- Casework: CMS identified QHP 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 QHP 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).
- Enrollment Process for Qualified Individuals (Privacy and Security Policies)^{*}: CMS identified issues with QHP issuers' privacy and security policies, or in some cases, specific incidents where the QHP 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 call within the timeframes required under the FFE privacy and security policies pursuant to 45 CFR § 155.260 and § 156.265(b)(3)(iii).
- Agent and Broker Oversight^{*}: CMS identified issues with inadequate monitoring of affiliated agents and brokers (i.e., QHP 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).

CMS recommends QHP issuers 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 QHP 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 QHP issuers as part of the full

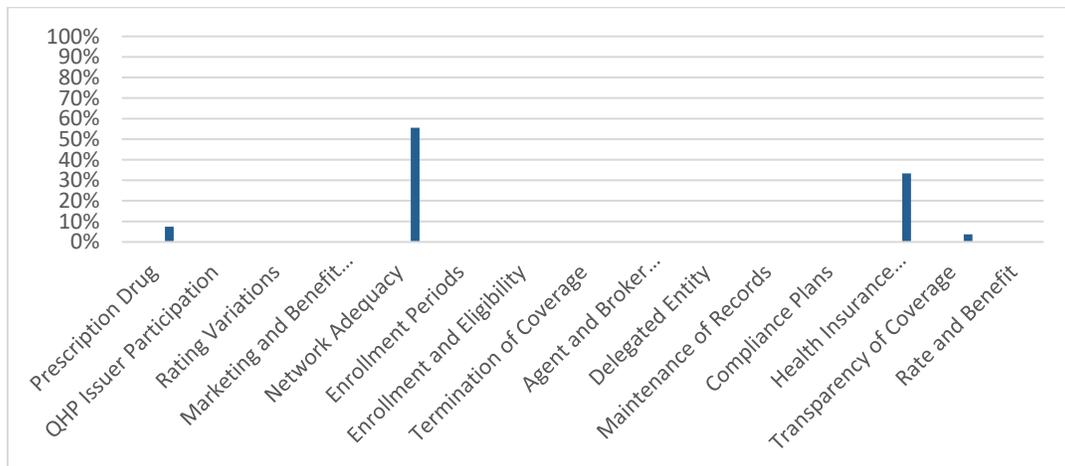
⁴ The protocol sections with an asterisk were not included as part of the PY 2020 modified compliance reviews.

compliance reviews with findings and observations in each review area; QHP issuers may have had multiple results in an area for the full compliance review. Figure 2 displays the percentage of reviewed QHP issuers as part of the modified compliance reviews with observations in each review area; QHP issuers may have had multiple results in an area for modified compliance reviews.

**Figure 1: Percentage of QHP issuers Reviewed with Findings and Observations by Area⁵
(Full Compliance Reviews)**



**Figure 2: Percentage of QHP issuers Reviewed with Observations by Area
(Modified Compliance Reviews)**



⁵ These statistics represent the percentage of QHP issuers reviewed with Findings or Observations attributed to a particular review area. Scoring may represent multiple Findings attributed to the same area, as seen under Network Adequacy that includes Findings or Observations for provider directory, machine readable data files, and ECP contracting areas tested under one combined heading, which resulted in more than one Finding or Observation in several review areas.

2. COMPLIANCE REVIEW PROCESS

Under 45 CFR § 155.1010(a)(2) and § 156.715, CMS has the authority to perform compliance reviews of QHP issuers offering QHPs, including SADPs, in the FFEs to ensure ongoing compliance with requirements for QHP certification under 45 CFR Part 156 and other FFE standards. FFE compliance reviews may help QHP 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. Figure 3 depicts a visual representation of the steps in the FFE full compliance review process. CMS also released the *Key Priorities for Federally-facilitated Exchange Compliance Reviews for the 2020 Plan Year*, which sets forth a list of regulatory standards that CMS planned to include in the PY 2020 compliance reviews. This document is available at: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-Key-Priorities-Table-Final.pdf>.

Figure 3: The FFE Full Compliance Review Process



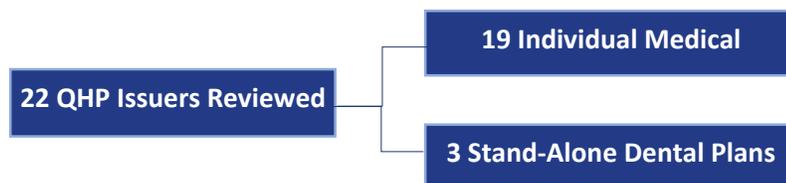
CMS selects QHP issuers for a full compliance review based on performance data and ongoing monitoring activities. For PY 2020, CMS initially selected 22 QHP issuer identification numbers; however, to reduce burdens during the COVID-19 PHE, CMS conducted full compliance reviews on 7 of the selected QHP issuer identification numbers. Beginning in August 2020, CMS issued notifications to the selected QHP issuers and conducted kick-off calls to discuss each QHP issuer's selection and the compliance review process, as well as to inform the QHP issuer of any documentation needed prior to start of the review. After receiving and reviewing the requested documentation, CMS conducted interviews with each QHP issuer's staff about its FFE operations.

Figure 4: The FFE Modified Compliance Review Process



Of the original 22 QHP issuer identification numbers selected for PY 2020 compliance review, CMS decided to conduct modified compliance reviews on the remaining 15 QHP issuer identification numbers to reduce burdens on QHP issuers during the COVID-19 PHE. Beginning in June 2020, CMS gathered a QHP issuer's certification documents and engaged in internet research prior to start of the compliance review testing.

Figure 5 shows a breakdown of the QHP issuer characteristics for PY 2020 compliance reviews (combining both the full and modified compliance reviews).

Figure 5: Issuer Characteristics for PY 2020 Compliance Reviews

The PY 2020 compliance reviews consisted of 7 full desk reviews (encompassing 6 QHPs and 1 SADP) and 15 modified desk reviews (encompassing 13 QHPs and 2 SADPs).⁶ During each full compliance review, CMS: 1) reviewed QHP issuers' policies, procedures, and processes for all 17 review areas included within the scope of the review; and 2) performed testing for 13 of the 17 review areas to assess compliance with FFE regulations.

Due to the COVID-19 PHE, CMS conducted modified compliance reviews to reduce burdens on issuers by eliminating the need for QHP issuer participation and submission of documentation. In addition, several review areas were not included as part of these reviews.⁷ During each modified review, CMS: 1) reviewed the QHP issuer's certification documents in the nine review areas included within the scope of these reviews, and 2) performed testing for five of the nine review areas to assess compliance with FFE regulations.

The next sections detail the results of the PY 2020 full and modified compliance reviews by review area. The PY 2020 full compliance reviews continued to focus more on QHP issuers' processes and performance, and less on their written policies and procedures than prior years. Written policies and procedures were requested and reviewed as part of the full compliance reviews to aid CMS in determining whether a QHP issuer's processes complied with FFE requirements.

3. FULL COMPLIANCE REVIEW RESULTS

Findings and observations contained in this section align with the 17 review areas noted in the Executive Summary and associated regulatory standards. Tables 1-17 present findings and observations for each of the 17 review areas for the full compliance reviews. Findings result from discovery of evidence suggesting noncompliance, in addition to cases of confirmed or admitted noncompliance. Observations result from discovery of evidence of practices or procedures that represent a compliance risk, but there was no evidence of noncompliance, in addition to identification of areas for improvement.

CMS classified findings and observations⁸ based on the type of review methodology⁹ employed:

⁶ CMS conducted desk reviews, using telephone interviews, webinars, website research, and email to collect the necessary information and documents for review.

⁷ The 17 review areas were evaluated to identify and remove those areas that required QHP issuer participation and submission of documentation.

⁸ Review areas may contain findings, observations, or both, depending on testing results.

⁹ Information about the CMS review methodologies is provided as a high-level overview of the review processes completed for each area under review. This information is not sufficiently detailed to complete a similar review and replicate CMS's results.

- **Process Review:** This included review of QHP issuers' written processes and procedures for review areas within the scope of the PY 2020 full compliance reviews. Throughout these full compliance reviews, CMS requested and examined applicable policies and procedures established and provided by the QHP 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 QHP issuers' compliance with FFE regulations for review areas within the scope of the PY 2020 full 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 17 review areas, the methodology CMS used to review QHP issuer compliance, any associated findings and observations, and suggested best practices for review areas that produced findings or observations.

3.1 Prescription Drug Formulary

Pursuant to 45 CFR § 156.200(b)(3), a QHP issuer must ensure that each QHP complies with benefit design standards, defined at § 156.20 to mean the essential health benefits (EHB) package. Pursuant to 45 CFR § 156.122, a QHP issuer's health plan provides EHB 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 their 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 QHP issuers' websites against those submitted as part of the PY 2020 QHP certification process to determine whether there were significant changes to the formularies since certification that could be prohibited by non-discrimination requirements specified at 45 CFR § 156.125 and § 156.225(b). In addition, CMS reviewed the QHP issuers' 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 QHP 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	Findings Count	Observations Count
Process Testing	<ul style="list-style-type: none"> ▪ Non-formulary drug exception request policy is not complete (e.g., policy does not include all of the standards for making a determination and notifying an enrollee of the coverage determination on non-formulary drug exceptions). 	0	1

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 § 155.706;
- 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, or sex; 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.¹⁰ CMS also reviewed

¹⁰ The evaluation of the non-discrimination policies was modified in 2019 to deem the QHP issuer’s policy compliant if it mirrored the statutory language in Section 1557 of the Patient Protection and Affordable Care Act.

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 QHP 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	Findings Count	Observations Count
Process Testing	<ul style="list-style-type: none"> No findings or observations were identified in this review area. 	0	0

3.2.3 Best Practices

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

Develop and monitor compensation practices to ensure that Exchange status is not considered when determining the rate of compensation for an agent or broker.

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 QHP 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	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No findings were identified in this review area. 	0	N/A*

*Compliance review protocols do not allow observations for this review area.

3.3.3 Best Practices

Establish an annual process to ensure a justification is posted to the QHP 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 QHP issuer websites to determine if the QHP 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	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Claims transparency information was not provided or did not include all required information. 	2	N/A*
	<ul style="list-style-type: none"> ▪ Claims transparency information URL was not easily assessable. 	0	1

*Compliance review protocols do not allow observations for this type of finding.

3.4.3 Best Practices

Establish an annual process to ensure the required information is posted to the QHP 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 in QHPs.

3.5.1 CMS Review Methodology

CMS reviewed QHP 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	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ No findings or observations were identified in this review area. 	0	0

3.5.3 Best Practices

Establish and use 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 use 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 Network Adequacy

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

- Maintaining a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay, and that it is consistent with the network adequacy provisions of Section 2702(c) of the Public Health Service Act;
- Making an accurate, complete, 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 in their provider directories which providers are not accepting new patients.

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 and provides medical or dental services that are covered by the issuer plan type.

3.6.1 CMS Review Methodology

CMS evaluated the QHP 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 and is accurately recorded in the provider directory.

CMS accessed the QHP issuers' online and machine-readable provider directory data files and selected a sample of providers from different specialty groups from each source. Each provider office in the sample was analyzed using the provider's website, other internet resources, or telephone calls to confirm that the demographic information published in the directory was up-to-date, accurate, and complete. The information gathered during this internet search was documented and compared against the source data 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 QHP issuer also created a stand-alone hard copy directory, CMS determined if the information contained within it was consistent with the online directory.

CMS's testing of this review area also included a comparison of the QHPs' ECP lists against the *HHS 2020 Non-Exhaustive List of ECPs* to identify if there were any counties and/or specialties within the QHPs' services areas that did not meet the FFE requirements for ECPs. In those counties where QHPs did not meet ECP requirements, CMS requested documentation that the QHP 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: Network Adequacy Findings or Observations¹¹

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> Provider directories contained incorrect information pertaining to one or more of the following details: medical group affiliation, specialty, address, phone number, and status of accepting new patients (e.g., some sampled providers were no longer in practice and/or had incorrect contact information). 	0	7

¹¹ There was a total of 9 findings in this area for 7 QHP issuers reviewed. Several QHP issuers had multiple findings and every QHP issuer received at least one finding in this review area. The provider directory is listed as an observation as CMS did not contact the providers due to the COVID-19 public health emergency (PHE). CMS was unable to verify enough information telephonically to indicate a Finding. However, there were enough indicators during the testing that was completed to prompt an observational Finding.

Review Methodology	Findings or Observations	Findings Count	Observations Count
	<ul style="list-style-type: none"> ▪ QHP 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). 	2	0

3.6.3 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, complete, 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 Premium Rate Variations

Pursuant to 45 CFR § 147.102(a) and § 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 QHP 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.

3.7.1 CMS Review Methodology

CMS performed comparisons of the premiums for QHPs sold on- and off-Exchange to determine if the rates being charged were comparable¹² for similar plans.

3.7.2 Results

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

¹² The definition of "comparable" for this evaluation was determined to be a variance between similar QHPs of less than one dollar per month.

Table 7: Premium Rate Variation Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No findings were identified related to this review area. 	0	N/A*

*Compliance review protocols do not allow observations for this review area.

3.7.3 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.

3.8 Other Notices for Special Enrollment Periods for Qualified Individuals

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

3.8.1 CMS Review Methodology

CMS reviewed certification records to determine if a QHP issuer had been required to make a notification to its enrollees. If the QHP 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 had used the approved notification template.

3.8.2 Results

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

Table 8: Other Notices for Special Enrollment Periods Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No findings were identified related to this review area. 	0	N/A*

*Compliance review protocols do not allow observations for this review area.

3.8.3 Best Practices

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

3.9 Enrollment Process for Qualified Individuals

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

- Enrolling a qualified individual through the Exchanges if they receive an eligibility determination from the Exchange;
- Accepting enrollment information consistent with applicable Exchange privacy and security requirements;
- Ensuring the process used to complete the eligibility application complies with all Exchange standards, including applicable 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
- Verify to the Exchange that the enrollment information has been received.

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.

3.9.1 CMS Review Methodology

CMS reviewed enrollment processes, new enrollment packages, and processes for reconciling enrollment files with the FFEs. To evaluate QHP 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 QHP issuer compliance with FFE third-party payment acceptance requirements, CMS reviewed the QHP issuers' premium acceptance policy, and through written and verbal communication, identified the QHP issuers' processes related to the acceptance of third-party payments for enrollee premiums.

3.9.2 Results

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

Table 9: Enrollment Process Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ QHP 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. 	2	0

Review Methodology	Findings or Observations	Findings Count	Observations Count
Process Testing	<ul style="list-style-type: none"> QHP 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. 	0	2

3.9.3 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 and contain all required information.

3.10 Termination of Coverage for Qualified Individuals

Pursuant to 45 CFR § 156.270, QHP 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.

3.10.1 CMS Review Methodology

CMS reviewed QHP 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 QHP 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 QHP issuers' record maintenance written policies specific to termination of coverage. CMS also conducted performance testing on payment delinquency notices to determine whether QHP issuers sent them within appropriate timeframes.

3.10.2 Results

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

Table 10: Termination of Coverage Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ QHP issuer did not establish a standard written policy for the termination of enrollees due to non-payment of premiums.	2	0
	▪ QHP issuer did not send termination notices to all enrollees, or they were sent with undue delay.	0	1
	▪ Termination notices did not include a reason for termination.	2	0
	▪ Enrollees receiving APTC were not provided a 3 consecutive months' grace period.	1	0
	▪ Delinquency notice identified a termination date if the enrollee did not pay all outstanding premiums in full prior to the end of the grace period; date was different than termination date included in the certificate of coverage.	1	0

3.10.3 Best Practices

- Regularly review termination-of-coverage policy to ensure all standards for the termination of enrollment due to non-payment or premium are included in the termination policy.
- Regularly review termination-of-coverage operations to ensure processes are working as intended, and notices are sent promptly and with the required content.

3.11 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.

3.11.1 MS Review Methodology

CMS reviewed QHP issuers' written policies and procedures related to affiliated agent and broker onboarding. CMS then cross-referenced QHP issuers' submitted lists of National Producer Numbers (NPNs) for affiliated agents and brokers who assisted with PY 2020 enrollments against the published *CMS Agent and Broker FFE Registration Completion List for Plan Year 2020*¹³ to determine if each affiliated agent or broker had completed the required FFE registration and training for PY 2020. CMS also compared the registration completion dates of those registered agents or brokers with the date of

¹³ Available at <https://data.healthcare.gov/dataset/AB-Registration-Completion-List/wb6u-x2ny/data>.

the first enrollment they assisted with for PY 2020 to determine if the affiliated agents or brokers were assisting with enrollment prior to having completed the registration and training process.

3.11.2 Results

Table 12 lists findings or observations for this review area.

Table 11: Agent and Broker Oversight Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ NPNs for affiliated agents, brokers, or agencies did not match CMS's records, indicating that they had not completed the required FFE registration and training process for PY 2020. 	0	2

3.11.3 Best Practices

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

3.12 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 in part: 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).

3.12.1 CMS Review Methodology

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

- Specifies the delegated activities and reporting responsibilities;
- Provides for revocation of the delegation or other remedies when HHS or the QHP issuer determines that 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 QHP 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.

3.12.2 Results

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

Table 12: Delegated and Downstream Entity Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ QHP issuer's downstream and delegated entity agreements (including any amendments thereto) did not include all of the language required by 45 CFR § 156.340. 	4	0

3.12.3 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.

3.13 Maintenance of Records

Pursuant to 45 CFR § 156.705, QHP 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, QHP issuers must make available all records that are necessary for HHS to conduct financial audits and compliance reviews.

3.13.1 CMS Review Methodology

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

Findings or observations related to this review area were identified if record retention timeframes did not meet requirements or if the QHP issuer was unable to supply a record or document requested as part of testing.

3.13.2 Results

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

Table 13: Maintenance of Records Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> QHP issuer's record retention schedule and policy did not reflect the required record retention timeframe.¹⁴ 	0	1

3.13.3 Best Practices

Update written record-retention policies, and provide applicable staff training, to ensure records are maintained and accessible upon request for the required 10-year period.

3.14 Compliance Plans

Pursuant to 45 CFR § 156.715, QHP 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 QHP issuer's books and contracts, including policy manuals and other plan benefit information provided to enrollees;
- The QHP 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.

3.14.1 CMS Review Methodology

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

3.14.2 Results

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

Table 14: Compliance Plan Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No findings or observations were identified related to this review area. 	0	0

3.14.3 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

¹⁴ A finding of this type was most recently previously identified in 2018; policies and procedures regarding record retention were reviewed but no errors, findings, or observations were identified in this area for 2019.

remaining compliant with each regulation as well as providing punitive and corrective actions should they be required.

3.15 Casework

Pursuant to 45 CFR § 156.1010, QHP issuers in an FFE must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS¹⁵;
- Resolve non-urgent cases (for cases forwarded by HHS) no later than 15 calendar days after receipt of the case, and urgent cases no later than 72 hours after the case is received;
- Provide notice¹⁶ 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 business days of completion with a clear and concise explanation of the how the case was resolved.

3.15.1 CMS Review Methodology

CMS reviewed the casework documentation submitted by each QHP issuer for a sample of cases selected by CMS for review. The submitted documentation included 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 QHP 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 manner¹⁷; 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 HICS within 7 business days after resolution.

3.15.2 Results

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

¹⁵ CMS records casework in the Health Insurance Casework System (HICS), a web application that CMS requires QHP issuers operating in FFEs to use for casework intake and resolution activities.

¹⁶ 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.

¹⁷ For purposes of these compliance reviews, “timely manner” was considered to be within 2 weeks of the verbal notification, barring exceptional circumstances.

Table 15: Casework Findings or Observations¹⁸

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ Written case resolutions notifications were not provided to complainants in a timely manner for cases where the complainant was initially notified verbally of the case disposition.	1	0
	▪ HICS cases records did not include information about how and when the complainant was notified of the resolution.	1	0
	▪ QHP issuer sent certificate of coverage instead of sending written case resolution notification.	1	0
	▪ HICS written notification were not provided to the complainant.	1	0
	▪ Cases were not resolved within the timelines established by the Exchange.	1	0
	▪ Resolution summary within HICS did not include resolution information.	0	1

3.15.3 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.

3.16 Patient Safety Standards

Pursuant to 45 CFR § 156.1110, QHP issuers that contract with a hospital with greater than 50 beds must verify that the hospital meets the following patient safety standards:

- Adoption of a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient and utilizes a patient safety evaluation system as defined in 42 CFR § 3.20 (i.e., has a current agreement or other information demonstrating a partnership with a Patient Safety Organization (PSO)); or
- Establishment of an evidence-based initiative, to improve health care quality through the collection, management, and analysis of patient safety events that reduces all cause-preventable harm, prevents hospital readmission, or improves care coordination.

3.16.1 CMS Review Methodology

CMS reviewed the QHP issuer's policy or process to ensure that contracted hospitals with more than 50 beds meet the patient safety standards. If the QHP issuer does not have a policy or process, CMS

¹⁸ A total of 6 findings or observations were recorded in this review area for 4 QHP issuers. Several findings had multiple elements contained within them resulting in the totals represented in this table.

analyzes the hospital service contract to identify how the hospital demonstrates it meets the required patient safety standards.

3.16.2 Results

Table 17 lists findings or observations related to this review area.

Table 16: Patient Safety Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Process Review	<ul style="list-style-type: none"> ▪ No findings or observations were identified related to this review area. 	0	0

3.16.1 Best Practices

Verify the contracted hospital has a partnership with a Patient Safety Organization or has established an evidence-based initiative to improve health care quality.

4. FULL COMPLIANCE REVIEW CONCLUSION

In PY 2020, full compliance reviews were conducted for 7 FFE QHP issuer identification numbers representing 7 distinct parent companies in 7 FFE states. This included 6 individual market issuers and 1 SADP. All of the full compliance reviews were completed through desk reviews.

Review areas that frequently included findings or observations in 2020 were also identified in 2018 and 2019. These findings or observations included:

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

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2017 and 2020, 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 QHP issuer compliance while remaining efficient. The insights gained from FFE compliance reviews will continue to inform future guidance and regulatory updates.

5. MODIFIED COMPLIANCE REVIEW RESULTS

Due to the COVID-19 PHE, CMS modified the compliance review process to reduce the burden on QHP issuers by eliminating the need for QHP issuer participation and submission of documentation. As

detailed further below, we also focused these reviews on a subset of the review areas included in the PY 2020 full compliance reviews. Out of the initial 22 QHP issuer identification numbers selected for PY 2020 compliance reviews, 15 were selected to undergo a modified compliance review. For these reviews, information was gathered using available sources such as the internet, PY 2020 QHP issuer certification submissions, and the Health Insurance Casework System (HICS).

The areas included in these modified compliance reviews included QHP rate and benefit information, transparency in coverage, marketing and benefit design, network provider directory, rating variations, handling of complainants, and pharmacy and formulary benefits. Due to CMS' limitation to communicate with the QHP issuer and the inability to validate the information tested, any findings were identified as an observation only due to the COVID-19 PHE. CMS was unable to validate Findings with issuers due to the limitations during the COVID-19 PHE. Observations contained in this report align with 9 of the 17 review areas noted in the Executive Summary and associated regulatory standards. Tables 1-9 present observations for each of the nine review areas. Observations result from discovery of evidence of practices or procedures that represent a compliance risk, but there was no evidence of noncompliance, in addition to identifying areas for improvement.

CMS classified observations based on the type of review methodology¹⁹ employed:

- **Performance Testing:** This included testing to assess QHP issuers' compliance with FFE regulations for review areas included in the PY 2020 modified 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 nine review areas, the methodology CMS used to review QHP issuer compliance, any associated observations, and suggested best practices for review areas that produced observations.

5.1 Prescription Drug Formulary

Pursuant to 45 CFR § 156.200(b)(3), a QHP issuer must ensure that each QHP complies with benefit design standards, defined at § 156.20 to mean the EHB package. Pursuant to 45 CFR § 156.122, a QHP issuer's health plan provides EHB 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 OPM;
- 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.

¹⁹ Information about the CMS review methodologies is provided as a high-level overview of the review processes completed for each area under review. This information is not sufficiently detailed to complete a similar review and replicate CMS's results.

5.1.1 CMS Review Methodology

CMS reviewed prescription drug formularies available on the QHP issuers' websites against those submitted as part of the PY 2020 QHP certification process to determine whether there were significant changes to the formularies since certification that could be prohibited by non-discrimination requirements specified at 45 CFR § 156.125 and § 156.225(b). In addition, CMS reviewed the QHP issuers' 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 QHP issuer's formulary to determine if the formulary contained the information required by 45 CFR § 156.122(d).

5.1.2 Results

Table 18 lists findings or observations related to this review area.

Table 17: Prescription Drug Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Online formulary does not define the tiering structure. 	N/A	2

5.1.3 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.

5.2 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.

5.2.1 CMS Review Methodology

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

5.2.2 Results

Table 19 lists findings or observations related to this review area.

Table 18: Rates and Benefits Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No observations were identified in this review area. 	N/A	0

5.2.3 Best Practices

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

5.3 Transparency in Coverage

Pursuant to 45 CFR § 156.220, QHP issuers must provide specific information in accordance with the regulation to the Exchange, the 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.

5.3.1 CMS Review Methodology

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

5.3.2 Results

Table 20 lists findings or observations related to this review area.

Table 19: Transparency in Coverage Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> Claims transparency information was not provided or did not include all required information. 	N/A	1

5.3.3 Best Practices

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

5.4 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 in QHPs.

5.4.1 CMS Review Methodology

CMS reviewed QHP issuers' certificates of coverage to confirm the plan documents do not contain discriminatory language or statements that could have the effect of discouraging the enrollment of individuals with significant health needs.

5.4.2 Results

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

Table 20: Marketing and Benefit Design Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ No observations were identified in this review area. 	N/A	0

5.4.3 Best Practices

Establish and use a process that evaluates and monitors the certificate of coverage for each product to ensure plan documents will not have the effect of discouraging the enrollment of individuals with significant health needs.

5.5 Network Adequacy

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

- Maintaining a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure 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, complete, 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 in their provider directories which providers are not accepting new patients.

5.5.1 CMS Review Methodology

CMS evaluated the QHP 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 and is accurately recorded in the provider directory.

CMS accessed the QHP issuers' online and machine-readable provider directory data files and selected a sample of providers from different specialty groups from each source. Each provider office in the sample was analyzed using the provider's website or other internet resources to confirm that the demographic information published in the directory was up-to-date, accurate, and complete. The information gathered during this internet search was documented and compared against the source data 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.

5.5.2 Results

Table 22 lists findings or observations related to this review area.

Table 21: Network Adequacy Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> Provider directories contained incorrect information pertaining to one or more of the following details: medical group affiliation, specialty, address, phone number, and status of accepting new patients (e.g., some sampled providers were no longer in practice and/or had incorrect contact information). 	N/A	15

5.5.3 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, complete, and up-to-date as possible.

Use provider data within claims submission and payment processing systems to evaluate possibly incorrect data elements.

5.6 Premium Rate Variations

Pursuant to 45 CFR § 147.102(a) and § 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 QHP 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.

5.6.1 CMS Review Methodology

CMS performed comparisons of the premiums for QHPs sold on- and off-Exchange to determine if the rates being charged were comparable²⁰ for similar plans.

5.6.2 Results

Table 24 lists findings or observations related to this review area.

²⁰ The definition of “comparable” for this evaluation was determined to be a variance between similar QHPs of less than one dollar per month.

Table 22: Premium Rate Variation Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No observations were identified related to this review area. 	N/A	0

5.6.3 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.

5.7 Compliance Plans

Pursuant to 45 CFR § 156.715, QHP 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 QHP issuer's books and contracts, including policy manuals and other plan benefit information provided to enrollees;
- The QHP 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.

5.7.1 CMS Review Methodology

To evaluate compliance with these standards, CMS reviewed compliance plans submitted by QHP issuers during the PY 2020 QHP Certification process.

5.7.2 Results

Table 25 lists findings or observations related to this review area.

Table 23: Compliance Plan Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> No observations were identified related to this review area. 	N/A	0

5.7.3 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.

5.8 Casework

Pursuant to 45 CFR § 156.1010, QHP issuers in an FFE must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS²¹;
- Resolve non-urgent cases (for cases forwarded by HHS) no later than 15 calendar days after receipt of the case, and urgent cases no later than 72 hours after the case is received;
- Provide notice²² 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 HICS within 7 business days of completion with a clear and concise explanation of the how the case was resolved.

5.8.1 CMS Review Methodology

CMS reviewed a sample of the casework documentation extracted from the HICS system. The extracted documentation included 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 QHP 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 manner²³; 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.

5.8.2 Results

Table 26 lists findings or observations related to this review area.

Table 24: Casework Findings or Observations²⁴

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ HICS cases were not resolved within the timelines established by the Exchange.	N/A	7
	▪ HICS cases resolution summaries did not include information about how and when the complaint was notified of the resolution.	N/A	7

²¹ CMS records casework in HICS, a web application that CMS requires QHP issuers operating in FFEs to use for casework intake and resolution activities.

²² 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.

²³ For purposes of these compliance reviews, “timely manner” was considered to be within 2 weeks of the verbal notification, barring exceptional circumstances.

²⁴ A total of 15 findings was recorded in this area for 9 QHP issuers reviewed. Several findings had multiple elements within them, resulting in the total represented in this chart.

Review Methodology	Findings or Observations	Findings Count	Observations Count
	<ul style="list-style-type: none"> ▪ HICS case resolution summaries were not entered in HICS within 7 business days. 	N/A	1

5.8.3 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.

6. MODIFIED COMPLIANCE REVIEW CONCLUSION

In PY 2020, modified compliance reviews were conducted for 15 FFE QHP issuer identification numbers representing 15 distinct parent companies in 13 FFE states. This included 13 individual market issuers and 2 SADPs. All modified compliance reviews were completed through desk reviews.

Review areas that frequently included observations in 2020 were also identified in 2018 and 2019. These observations included:

- Ensuring accurate and up-to-date provider directory information as required by 45 CFR § 156.230(b)(2);

- Not providing claims transparency information or not including all information required by 45 CFR § 156.220(b)(c); and

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

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2017 and 2020, 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 QHP issuer compliance while remaining efficient. The insights gained from FFE compliance reviews will continue to inform future guidance and regulatory updates.

7. APPENDIX 1 – Finding or Observation Count by Review Area and De-Identified Issuer – Full Compliance Review

De-identified Issuer Information	Agent and Broker	Casework	Delegated Entity	Enrollment and Eligibility		Network Adequacy	Prescription Drug	Record Retention	Termination of Coverage	Transparency in Coverage	Grand Total
2020-1		1	1			1			1		4
2020-2		1		1		2			1		5
2020-3											
2020-4				1		1			1		3
2020-5											
2020-6											
2020-7				1		1			1		3
2020-8											
2020-9											
2020-10		1	1	1		2	1	1	1	1	9
2020-11											
2020-12											
2020-13											
2020-14											
2020-15											
2020-16											
2020-17	1		1			1			1	1	6
2020-18											
2020-19											
2020-20											
2020-21											
2020-22	1	1	1			1			1	1	6
Grand Total	2	4	4	4		9	1	1	7	3	35

The appendix above contains the actual count of each finding or observation recorded by compliance review area and by de-identified QHP issuer. The information in this chart represents only those review areas for which there was an identified finding or observation recorded; the remaining areas have been excluded for readability and due to space constraints.

8. APPENDIX 2 – Observation Count by Review Area and De-Identified Issuer – Modified Compliance Review

De-identified Issuer Information	Agent and Broker	Casework	Delegated Entity	Enrollment and Eligibility		Network Adequacy	Prescription Drug	Record Retention	Termination of Coverage	Transparency in Coverage	Grand Total
2020-1											
2020-2											
2020-3						1					1
2020-4											
2020-5		1				1					2
2020-6		1				1					2
2020-7											
2020-8						1	1				2
2020-9						1					1
2020-10											
2020-11		1				1					2
2020-12		1				1					2
2020-13		1				1				1	3
2020-14		1				1					2
2020-15		1				1					2
2020-16						1					1
2020-17											
2020-18		1				1					2
2020-19						1					1
2020-20						1					1
2020-21		1				1	1				3
2020-22											
Grand Total		9				15	2			1	27

The appendix above contains the actual count of each observation recorded by compliance review area and by de-identified QHP issuer. The information in this chart represents only those review areas for which there was an identified observation recorded; the remaining areas have been excluded for readability and due to space constraints.