



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

**2024 Plan Year
Federally-Facilitated Exchange
Issuer Compliance Review Summary Report**

April 17, 2026

Table of Contents

1. EXECUTIVE SUMMARY	3
2. COMPLIANCE REVIEW PROCESS	6
3. COMPLIANCE REVIEW RESULTS.....	7
3.1 Prescription Drug Benefits	8
3.2 QHP Issuer Participation Standards	9
3.3 QHP Rate and Benefit Information.....	10
3.4 Transparency in Coverage	11
3.5 Access to and exchange of health data and plan information.....	12
3.6 Marketing and Benefit Design	14
3.7 Network Adequacy	15
3.8 Meaningful Access.....	18
3.9 Premium Rate Variations	19
3.10 Other Notices for Special Enrollment Periods for Qualified Individuals	19
3.11 Enrollment Process for Qualified Individuals	20
3.12 Termination of Coverage for Qualified Individuals	22
3.13 Renewal and re-enrollment notices	23
3.14 Agent and Broker Oversight	25
3.15 Delegated and Downstream Entities.....	26
3.16 Maintenance of Records	27
3.17 Compliance Plans	28
3.18 Casework	29
3.19 Patient Safety Standards	30
3.20 Quality Rating System (QRS), Marketing Requirements	31
3.21 Data Integrity for Certification of QHPs	32
4. CONCLUSION.....	33
5. APPENDIX – Finding or Observation Count by Review Area and De-Identified QHP Issuer	34

1. EXECUTIVE SUMMARY

In accordance with the Patient Protection and Affordable Care Act (ACA), as amended, and pursuant to 45 C.F.R. §§ 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 requirements for QHP certification and other key FFE operational standards under 45 C.F.R. Part 156 (“Exchange-specific requirements”). FFE compliance reviews also help QHP issuers identify opportunities for improvement and provide CMS with insight into areas where additional guidance to issuers may be helpful.

This report summarizes the results from FFE compliance review activities related to plans certified as QHPs for Plan Year (PY) 2024.

Consistent with 45 C.F.R. §§ 155.1010(a)(2) and 156.715, CMS conducts compliance reviews of issuers offering QHPs, including stand-alone dental plan (SADP) QHPs, in the FFEs to ensure ongoing compliance with Exchange-specific requirements. For all QHP issuers that are selected to undergo a compliance review, CMS performs a risk-based assessment, where CMS considers certain performance measures. These measures may include evaluation of Post-Certification Assessment (PCA) data for the current and prior plan years, as well as review of whether a QHP issuer has encountered general compliance issues such as receipt of compliance letters: notices of non-compliance; suppressions; and de-certifications; consumer complaints and casework data from the Health Insurance Casework System (HICS).¹²³ CMS selected 21 QHP issuer identification numbers (IDs) from 14 FFE states⁴ for compliance reviews of plans certified and offered on the FFEs for PY 2024. These compliance reviews focused on QHP issuer processes and operational testing related to the following areas:

- Prescription drug benefits
- QHP issuer participation standards
- QHP rate and benefit information
- Transparency in coverage
- Access to and exchange of health data and plan information
- Marketing and benefit design

¹ After QHP certification is complete, CMS conducts PCA on selected QHP issuers to ensure compliance with FFE certification criteria and regulations. QHP issuers that are unable to fully address certification deficiencies or that have certain vulnerabilities identified during the PCA process have an increased likelihood of being selected for compliance reviews.

² CMS may review data from prior plan years based on determinations made during the risk assessment stage of the compliance review cycle, which involves assessing various performance measures that cause an issuer’s risk score to be adjusted downward or upward.

³ Under 45 C.F.R. 156.800, HHS may impose various sanctions on QHP issuers in an Exchange that are not in compliance with Exchange standards applicable to issuers offering QHPs in an Exchange, and more specifically at 45 C.F.R. 156.806, HHS may issue a written notice of non-compliance to a QHP issuer detailing the circumstances of its non-compliance prior to implementing more strict enforcement measures.

⁴ The 14 FFE states were AL, AZ, DE, FL, IL, MI, MO, MS, NC, OH, ND, TN, TX, and WI.

- Network adequacy
- Meaningful Access
- Other Notices for Special Enrollment Periods
- Enrollment processes for qualified individuals
- Enrollment processes for qualified individuals (privacy and security)
- Termination of coverage for qualified individuals
- QHP issuer oversight of delegated and downstream entities
- Agent and broker oversight
- Rating variations
- Health insurance casework system (HICS)
- Maintenance of records
- Patient safety standards
- Quality rating systems and marketing requirements
- Renewal and re-enrollment notices
- Compliance plans

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. Observations result from the discovery of evidence of practices or procedures which represent a compliance risk, but for which there was no evidence of actual noncompliance, in addition to identification of areas for improvement.

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. CMS made performance findings or observations primarily when a QHP issuer’s process included all 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 for and performance of a required activity.

The following review areas yielded the highest volume of 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 C.F.R. § 156.235(a)(2)(ii)(A) and (B); provider directories or machine-readable files that contained specific data elements were not up-to-date, complete, and accurate as required by 45 C.F.R. § 156.230(c), which requires QHP issuers to make the information described above available on its website in an HHS-specified format and also submit this information to HHS, in a format and manner and at times determined by HHS; and Time and
-

Distance standards were not met in certain categories as required by 45 C.F.R. § 156.230(a)(2)(i)(A).⁵

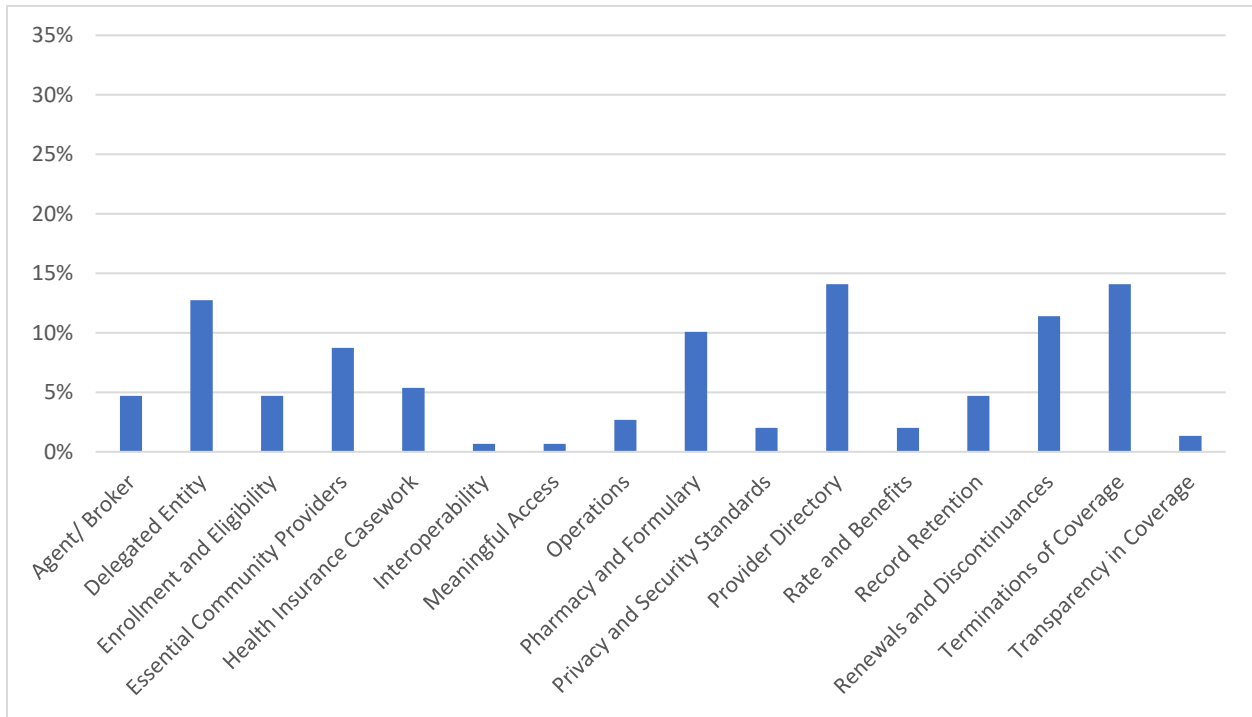
- **Downstream and Delegated Entities:** CMS identified QHP issuer downstream and delegated entity agreements that did not include the Exchange-specific language required by 45 C.F.R. § 156.340(b).
- **Casework:** CMS identified issues with the timely resolution, documentation, and complainant notification of HICS casework as required by 45 C.F.R. § 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 information required under 45 C.F.R. § 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 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 C.F.R. § 155.260 and § 156.265(b)(3)(iii).
- **Prescription Drug Benefit:** CMS identified issues with the timeliness of making determinations on standard, urgent coverage determination requests and standard, urgent appeals and notifying the enrollee or the enrollee's designee and the prescribing physician of its coverage determination.
- **Agent and Broker Oversight:** CMS identified issues with monitoring of agents and brokers affiliated with QHP issuers, as 45 C.F.R. § 156.340(a)(2) requires issuers participating in the Exchanges that use HealthCare.gov to ensure that their downstream and delegated entities comply with Federal standards related to Exchanges (e.g., QHP issuers did not consistently confirm whether their downstream agents and brokers had completed the required FFE registration and training before assisting Exchange consumers with enrollment).⁶

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 Exchange-specific requirements and processes and to have mechanisms in place to self-monitor compliance. Figure 1 displays the percentage of reviewed QHP issuers with findings and observations in each review area; QHP issuers may have had multiple results in an area.

⁵ 2018 Letter to Issuers, "[2018 Letter to Issuers](#) Directory Links and Provider Lookup Tool" (explicitly cites § 156.230(c), machine-readable requirement, monthly updates, and link submission); [CMS-10558 Supporting Statement \(explicitly cites § 156.230\(c\) and describes HHS-specified format/timing + posting\)](#); [CMS-10558 schema/appendix \(shows what the "specified format" looks like in practice—index + required URL arrays\)](#).

⁶ Agent Broker oversight is in reference to agents and brokers and not web-brokers. Exchange is defined as health insurance marketplace established under section 1311 of the ACA.

Figure 1: Percentage of QHP Issuers Reviewed with Findings and Observations by Area⁷

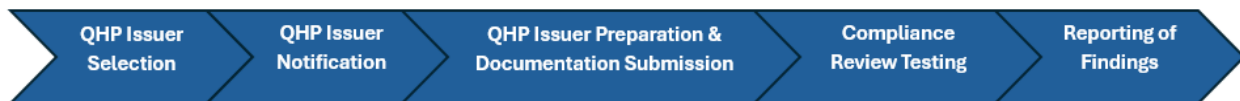


2. COMPLIANCE REVIEW PROCESS

The compliance review is a multi-phase process beginning with QHP issuer selection and culminating in a compliance review report for each issuer under review. This section provides an overview of the compliance review process. Figure 2 depicts the steps in the FFE compliance review process. CMS also released *Key Priorities for Federally-facilitated Exchange Compliance Reviews for the 2024 Plan Year*, which sets forth a list of regulatory standards that CMS considers to be of the highest priority in the PY 2024 compliance reviews. This document is available at:

<https://www.cms.gov/files/document/compliance-review-table-key-priorities-2024-final-022824-508.pdf>

Figure 2: The FFE Compliance Review Process

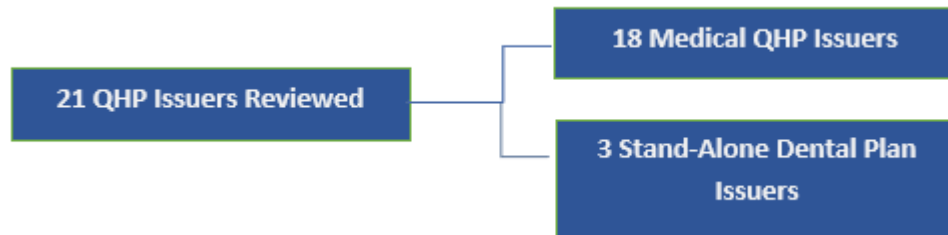


CMS selects QHP issuers for compliance reviews based on criteria related to performance data and ongoing monitoring activities. For PY 2024, CMS conducted compliance reviews of 21 QHP issuers with unique identification numbers. Beginning in April 2024, CMS issued notifications to the selected QHP

⁷ These statistics represent the percentage of QHP issuers reviewed with findings or observations attributed to a particular review area for plan year 2024. In the above table, one heading may represent a larger review area under which other sub-categories may come under, and multiple findings may be attributed to the same area.

issuers and conducted kick-off calls to discuss each QHP issuer's compliance review 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 performed testing and validation on the information submitted. CMS then conducted interviews with each QHP issuer's staff about its FFE operations. Figure 3 shows a breakdown of the QHP issuer characteristics for PY 2024 compliance reviews.

Figure 3: QHP Issuer Characteristics for PY 2024 Compliance Reviews



The PY 2024 compliance reviews consisted of 21 desk reviews (encompassing 18 medical QHP issuers and 3 SADP issuers).⁸ During each review, CMS: 1) reviewed QHP issuers' policies, procedures, and processes for all 21 review areas, and 2) performed testing for 17 of the 21 review areas to assess compliance with Exchange-specific requirements.

As part of the compliance review process, CMS works with QHP issuers to address findings. CMS requires QHP issuers to employ work plans to document how they intend to mitigate a finding and to state the intended timeline for resolution. Once the work plan is submitted, CMS validates that each change successfully corrects the issue which led to the finding. CMS does not deem a compliance review complete until all findings are resolved. The next section details the results of the PY 2024 compliance reviews by review area. The compliance reviews continued to focus more on QHP issuer processes and performance and less on written policies and procedures than in prior years. Written policies and procedures were requested and reviewed as part of the compliance review to aid CMS in determining whether a QHP issuer's processes complied with Exchange-specific requirements.

3. COMPLIANCE REVIEW RESULTS

Findings and observations contained in this report align with the 21 review areas noted in the Executive Summary and associated regulatory standards. Tables 1-21 present findings and observations for each of the 21 review areas. Findings result from the discovery of evidence suggesting noncompliance, in addition to cases of confirmed or admitted noncompliance. Observations result from the discovery of evidence of practices or procedures which represent a compliance risk, but for which there was no

⁸ CMS conducted desk reviews using Zoom interviews, website research, and email to collect the necessary information and documents for review.

evidence of noncompliance, in addition to identification of areas for improvement. CMS classified findings and observations based on the type of review methodology employed:⁹

- **Process Review:** This included review of QHP issuers' written processes and procedures for review areas within the scope of the PY 2024 compliance reviews. Throughout the reviews, CMS requested and examined relevant policies and procedures established by the QHP issuers.
- **Performance Testing:** This included testing to assess QHP issuers' compliance with Exchange-specific requirements regulations for review areas within the scope of the PY 2024 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 21 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 Benefits

Pursuant to 45 C.F.R. § 156.200(b)(3), a QHP issuer must ensure that each QHP complies with benefit design standards, defined at § 156.20 to mean in part the essential health benefits (EHB) package.

Pursuant to 45 C.F.R. § 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 a procedure in place to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of 45 C.F.R. § 156.122(c); 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 2024 QHP certification process to determine whether there were significant

⁹ Depending on the methodology used, Process Review and Performance Testing may result in findings, observations, or both. Some review or testing areas may include only findings because the applicable compliance review protocols do not permit observations in those areas. In Tables 1–21 below, CMS identifies these instances with the designation "N/A (Not Applicable)." The descriptions of CMS' review methodologies provide a high-level overview of the processes used for each area under review.

changes to the formularies since certification that could be prohibited by non-discrimination requirements specified at 45 C.F.R. § 156.125 and § 156.225(b). In addition, CMS reviewed the QHP issuer's drug formularies to determine if the number of specific drugs available met minimum threshold requirements of 45 C.F.R. § 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 C.F.R. § 156.122(c) and (d).

3.1.2 Results

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

Table 1: Prescription Drug Findings

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Non-formulary drug exception requests and/or appeals determination and notification were not completed in the required timeframe. 	15	N/A ⁹

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.
- Regularly review implementation of the drug exception appeal 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 Standards

Pursuant to 45 C.F.R. § 156.200, Exchange participation standards require a QHP issuer 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 C.F.R. § 155.706;
- 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 within a state.

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 provisions against discrimination based on all classes identified under the regulation.¹⁰ CMS also reviewed agent and broker compensation policies, comparing amounts paid for on- and off-Exchange coverage within a state, subscriber agreements, and lists of the QHPs (by type) offered under the participating QHP issuer IDs (See section 3.14).

3.2.2 Results

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

Table 2: QHP Issuer Participation Standards Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Process Testing	<ul style="list-style-type: none"> ▪ Non-discrimination policies, procedures, protocols, standard operating procedures, or other similar manuals omitted protected classes. 	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 (i.e., whether a consumer enrollment is in a health plan offered inside or outside the Exchange) is not considered when determining the rate of compensation for an agent or broker.

3.3 QHP Rate and Benefit Information

Pursuant to 45 C.F.R. § 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. CMS also reviewed routine pediatric vision and dental claims to determine whether eligible services are considered as appropriate with benefits, age, network, and other considerations such as frequency-of-service limitations.

3.3.2 Results

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

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 ACA.

Table 3: QHP Rates and Benefits Findings

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ Rate justification is not posted on the QHP issuer's website.	3	N/A ⁹
	▪ Vision claims were denied inappropriately due to the QHP issuer's internal system configuration error.	2	N/A ⁹

3.3.3 Best Practices

- Establish an annual process to ensure a justification is posted to the QHP issuer's website, consistent with Exchange-specific requirements.
- Establish a process to ensure claims are considered as appropriate for pediatric vision and pediatric dental benefits.

3.4 Transparency in Coverage¹¹

Pursuant to 45 C.F.R. § 156.220, a QHP issuer must provide specific information 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. A QHP issuer 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. CMS also accessed the QHP Issuer's Claims Payment Policies & Other Information URL to ensure it meets the minimum requirements in the plan year 2024 *Qualified Health Plan Issuer Application Instructions* by providing the following information in plain language:

- Out-of-network liability and balance billing;
- Enrollee claims submission;
- Grace periods and claims pending;
- Retroactive denials;
- Recoupment of overpayments;
- Medical necessity and prior authorization timeframes and enrollee responsibilities;
- Drug exception timeframes and enrollee responsibilities (not required for SADPs);
- Explanation of benefits (EOB); and
- Coordination of benefits (COB).

¹¹ Issuers of QHPs are subject to the Transparency in Coverage requirements applicable to QHPs in 45 C.F.R. § 156.220, which are addressed here. Issuers are also subject to additional market-wide Transparency in Coverage requirements in 45 C.F.R §§ 147.210-212, which are not addressed here.

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 ⁹
	<ul style="list-style-type: none"> Claims transparency information URL was not easily accessible.¹². 	0	N/A ⁹

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 and accurate.
- Ensure the QHP Issuer's Claims Payment Policies & Other Information URL meets the minimum requirement to make information available to the public and provide the information in plain language.

3.5 Access to and exchange of health data and plan information

Pursuant to 45 C.F.R. § 156.221(a), a QHP issuer on an FFE must implement and maintain a standards-based Application Programming Interface (API) that permits third-party applications to retrieve, with the approval and at the direction of a current individual enrollee or the enrollee's personal representative, data specified in § 156.221(b) through the use of common technologies and without special effort from the enrollee.

3.5.1 CMS Review Methodology

CMS reviewed QHP issuer websites to validate that the QHP issuer meets all documentation and technical standards, and to ensure that the QHP issuer meets the following requirements:

- Accessible content requirements under 45 C.F.R. § 156.221(b);
- Technical requirements under 45 C.F.R. § 156.221(c);
- Documentation requirements for APIs under 45 C.F.R. § 156.221(d);
- Denial or discontinuation of access to the API requirements under 45 C.F.R. § 156.221(e);
- Coordination among payer's requirements under 45 C.F.R. § 156.221(f);
- Enrollee resources regarding privacy and security requirements under 45 C.F.R. § 156.221(g); and
- Applicability requirements under 45 C.F.R. § 156.221(i).

¹² Refer to page number 17 in the plan year 2023 Qualified Health Plan Issuer Application Instructions.

3.5.2 Results

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

Table 5: Access to and exchange of health data and plan information Findings

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> Unable to locate the types of organizations not covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on QHP issuer’s website. 	1	N/A ⁹
	<ul style="list-style-type: none"> Unable to locate oversight responsibilities of the Federal Trade Commission (FTC) on QHP issuer’s website. 	1	N/A ⁹
	<ul style="list-style-type: none"> Unable to locate how to file a complaint with the OCR and FTC 	1	N/A ⁹
	<ul style="list-style-type: none"> Unable to locate operational link(s) for Office for Civil Rights (OCR) and FTC.¹³ 	1	N/A ⁹
	<ul style="list-style-type: none"> Unable to locate API information on the QHP issuer’s website. 	1	N/A ⁹
	<ul style="list-style-type: none"> Educational resources do not include an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities on the QHP issuer’s website. 	1	N/A ⁹
	<ul style="list-style-type: none"> Unable to ensure adjudicated claims are available no later than one business day after a claim is processed. 	0	N/A ⁹
	<ul style="list-style-type: none"> QHP issuer website does not provide information to enable third-party applications to transmit the API data types specified in 45 C.F.R. § 156.221(b)(1). 	0	N/A ⁹

3.5.3 Best Practices

- Ensure the QHP issuer has a publicly accessible website (or hyperlink to a third-party API vendor) for developers that instructs them on how they can retrieve healthcare information (i.e., software requirements, syntax functions names, technical requirements).
- The QHP issuer’s website includes general information on strategies enrollees may use to safeguard the privacy and security of their data.

¹³ CMS uses the term “operational” to mean active, functional, publicly accessible, and not broken. In this context, the QHP certification requirement for an operational link means the issuer’s website must maintain fully functioning links.

- The QHP issuer’s website contains general information regarding educational resources, including factors to be considered in selecting a third-party application for secondary uses of data and resources about the importance of understanding the privacy and security practices of any third-party application to which consumers will entrust their health information, and has an overview of which types of organization or individuals are or are not likely to be covered under HIPAA Privacy and Security rules.
- Ensure the educational resources include information on the oversight responsibilities of the OCR and the FTC and guidance on how to submit a complaint to the OCR and the FTC.
- Ensure the QHP issuer has established and maintained the API, making accessible to enrollees through the API all applicable data types such as clinical, cost, claims, etc., ensuring this data is available no later than one business day after a claim is processed, and providing information to enable third-party applications to use the API data.
- The QHP issuer has implemented the API standards and conducts routine testing, monitoring, and updates to ensure the API is functioning properly.
- The QHP issuer has implemented a process to determine whether a third-party application would present an unacceptable level of risk to the security of Protected Health Information (PHI)/Personally Identifiable Information (PII) on the QHP issuer’s systems.
- Ensure the QHP issuer has a process to deny/discontinue third-party access to the Patient Access API.
- Ensure the QHP issuer has a process for the exchange of enrollee data for the last five years, when the enrollee enrolls or disenrolls with the health plan.

3.6 Marketing and Benefit Design

Pursuant to 45 C.F.R. § 156.225(b), a QHP issuer may not employ marketing practices or benefit designs that have the effect of discouraging enrollment of individuals with significant health needs in QHPs.

3.6.1 CMS Review Methodology

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

3.6.2 Results

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

Table 6: 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

3.6.3 *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 in a manner that will result in the plan discriminating against individuals with significant health needs.
- Establish and use a process that evaluates and monitors the marketing practices for each product and plan to ensure that the marketing practices will not have the effect of discouraging the enrollment of individuals with significant health needs.

3.7 Network Adequacy

Pursuant to 45 C.F.R. § 156.230(a)(1)(ii)-(iii), (b)(1), and (b)(2), a QHP issuer with QHPs that use provider networks is required to:

- Maintain a network of in-network providers 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.
- Make an accurate and up-to-date provider directory available to the Exchange for publication online and provide a hard copy to potential enrollees upon request, including information on providers' location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM; and
- Identify which providers are not accepting new patients in their provider directories.

Pursuant to 45 C.F.R. §§ 156.230(a)(1)(i) and 156.235(a), a QHP issuer's provider networks must also include a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards. More specifically, at 45 C.F.R. § 156.235(a)(2)(i), CMS requires the QHP issuer's provider network should include as participating providers at least a minimum percentage, as specified by HHS, which under the current applicable specification for plan years beginning with PY 2023 and PY 2024 is 35 percent of available ECPs (and 35 percent of FQHCs and family planning providers). An ECP is a provider that serves predominantly low-income, medically underserved individuals. For a plan applying for QHP certification on the FFEs to satisfy that ECP requirement, the issuer must meet several requirements, including that it offers contracts in good faith to:

- All available Indian health care providers in the service area; and
- 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 QHP issuer plan type.

3.7.1 *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) the provider's location, contact information,

specialty, medical group, and any institutional affiliations are identified in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM.

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' testing of this review area also included a comparison of the QHP issuers' ECP lists against the [HHS 2024 Non-Exhaustive List of ECPs](#) to identify if there were any counties and/or specialties within the QHPs' services areas which did not meet the Exchange-specific requirements for ECPs.¹⁴ 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 available 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.

CMS' testing of this review area also included a review of the QHP issuer's Geo Access Report for each network to validate they have met the time and distance requirements outlined by CMS in the 2024 Letter to the Issuers Time and Distance Standards Table 3.1 (Individual Providers Specialty Types) and Table 3.2 (Facility Specialty Types).¹⁵ For SADPs, Table 3.3 lists the final time and distance standard for the dental provider type. CMS minimum requirement for time and distance is 90% across the board, regardless of specialty and geographic categories.

¹⁴ The HHS 2024 Non-Exhaustive List of ECPs is a federal reference list of healthcare providers that serve mostly low-income, medically underserved, or vulnerable populations. It exists to inform QHP issuers that they must include a sufficient number of ECPs in their provider networks and demonstrate that they are offering meaningful access to care for low-income and underserved populations.

¹⁵ The Geo Access Report is a document CMS requires QHP issuers to submit to show that its provider network is reasonably accessible to enrollees based on where they live, more specifically to ensure enrollees can reach doctors, hospitals, and other healthcare providers without unreasonable travel.

3.7.2 Results

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

Table 7: Network Adequacy Findings or Observations¹⁶

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 (<i>e.g.</i>, some sampled providers were no longer in practice and/or had incorrect contact information). 	21	1
	<ul style="list-style-type: none"> QHP issuer's ECP list did not meet all ECP contract offer requirements (<i>e.g.</i>, some QHP issuers did not offer contracts to one or more available Indian health care providers in their service area or could not provide documentation proving such contract offers were made). 	10	N/A ⁹
	<ul style="list-style-type: none"> Network Adequacy Justification report contained missing data and was not corrected before the final submission. 	0	N/A ⁹
	<ul style="list-style-type: none"> ECP could not be found in the provider directory. 	2	N/A ⁹
	<ul style="list-style-type: none"> Utilized the incorrect county code to measure time and distance. 	0	N/A ⁹
	<ul style="list-style-type: none"> SADP issuers did not meet the 35% threshold. 	1	N/A ⁹

3.7.3 Best Practices

- Regularly verify data in provider directories to ensure the accuracy of the information and make process improvements, when appropriate 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 incorrect provider data information.
- Create a process to evaluate network adequacy that includes procedures to remedy deficiencies that are identified.

¹⁶ A total of 43 findings in the Network Adequacy area for 18 QHP issuers reviewed is accurate, as several QHP issuers had multiple findings and every QHP issuer received a finding for network adequacy, specifically for provider directory deficiencies. The time and distance standards were met for all three SADP issuers.

- 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 under 45 C.F.R. 156.715(b).

3.8 Meaningful Access

Pursuant to 45 C.F.R. § 156.250, QHP issuers must provide meaningful access to certain information about QHPs, such as applications, forms, and notices, by ensuring the information is accessible to individuals living with disabilities and to individuals with limited English proficiency in accordance with 45 C.F.R. § 155.205(c). This includes providing auxiliary aids and services, written translations, and telephonic interpreter services in at least 150 languages, all at no cost to the individual. Additionally, if the QHP issuer maintains a website, it generally must translate the website into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant state. (Currently, only QHP issuers in Texas are subject to this requirement).

3.8.1 CMS Review Methodology

CMS reviewed the QHP issuer’s language translation policies and its website to ensure that the QHP issuer provides auxiliary aids and services for individuals living with disabilities, including the provision of Teletypewriter/Telecommunication Device for the Deaf (TTY/TDD), at no cost to the individual. Due to the population of non-English speakers exceeding 10 percent in Texas, CMS reviewed the QHP issuer’s website to determine if the website had been translated into Spanish. The website review is executed to ensure the QHP issuer’s website itself has translation capabilities and that translation is not being done by a standard browser capability (e.g., Google Chrome allows users to translate most pages to most languages).

Additionally, CMS reviewed the QHP issuer’s vendor contract, list of available languages, or internal policy or process that supports that the QHP issuer did provide oral translation services in at least 150 languages.

3.8.2 Results

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

Table 8: Meaningful Access Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Process Testing	<ul style="list-style-type: none"> ▪ Website was not translated into Spanish. 	1	N/A ⁹

3.8.3 Best Practices

- Establish a process to ensure the QHP issuer’s website includes information on auxiliary aids, language assistance, and services are available at no cost to the enrollee.

- For QHP issuers operating in Texas, they must translate their website into the non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population (Spanish). The translation should not be done by a standard browser capability (e.g., Google Chrome allows users to translate most pages for most languages)
- Establish a process to ensure that the QHP issuer translates verbal communication into at least 150 languages and provides written translations.

3.9 Premium Rate Variations

Pursuant to 45 C.F.R. §§ 147.102(a) and 156.255(b), a QHP issuer is 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.

3.9.1 CMS Review Methodology

CMS performed comparisons of the premiums for QHPs sold on- and off-Exchange to determine if the rates being charged were comparable to similar off-Exchange plans.¹⁷

3.9.2 Results

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

Table 9: 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 ⁹

3.9.3 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, directly through the QHP issuer, or through an agent.

3.10 Other Notices for Special Enrollment Periods for Qualified Individuals

Pursuant to 45 C.F.R. § 156.1256, a QHP issuer 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.

3.10.1 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,

¹⁷ The definition of "comparable" for this evaluation was determined to be a variance between similar QHPs of less than one dollar per month.

CMS selected a sample of impacted enrollees. The letters were reviewed to determine if they had been sent within the appropriate timeframes. In reviewing the letters, CMS also recommended the best practice of using a CMS-approved notification template, as doing so is not a regulatory requirement.

3.10.2 Results

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

Table 10: 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	0

3.10.3 Best Practices

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

3.11 Enrollment Process for Qualified Individuals

Pursuant to 45 C.F.R. § 156.265, a QHP issuer 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, including the Qualified Health Plan Certification Agreement and Privacy and Security Agreement;
- 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
- Verifying to the Exchange that the enrollment information has been received or timely describe any discrepancies.

3.11.1 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.

3.11.2 Results

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

Table 11: 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 implementing, 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. 	6	0
	<ul style="list-style-type: none"> ▪ Breaches and/or incidents were not reported to CMS IT Service Desk 	2	N/A ⁹
	<ul style="list-style-type: none"> ▪ QHP issuer does not have adequate process for reconciling enrollment files with the Exchange. 	0	N/A ⁹
	<ul style="list-style-type: none"> ▪ Members' records contained the incorrect CSR amounts. 	2	N/A ⁹
	<ul style="list-style-type: none"> ▪ Members' records contained the incorrect premium amounts. 	1	N/A ⁹
	<ul style="list-style-type: none"> ▪ Member's records contained the incorrect APTC amount. 	1	N/A ⁹

3.11.3 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 enrollee notification processes to monitor all mailings and document the timeframes for them to be sent.
- Monitor all enrollee mailings to ensure that letters or notifications are sent to enrollees as required and contain all required information, depending upon type of notification. For example, welcome package typical information:
 - Summary of Benefits and Coverage/Member Handbook
 - Prescription Drug Benefits Formulary
 - Provider Directory
 - Information about other coverage (if applicable)
 - Member ID Card

3.12 Termination of Coverage for Qualified Individuals

Pursuant to 45 C.F.R. § 156.270, a QHP issuer must adhere to termination-of-coverage processes in the individual market FFEs. These processes require QHP issuers to, among other things:

- Terminate coverage only under certain permitted circumstances;
- Provide termination-of-coverage notices promptly to affected enrollees promptly and without undue delay that includes the termination effective date and reason for termination, 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) including providing a grace period of 3 consecutive months;
- Provide payment delinquency notices to affected enrollees without undue delay, within 10 business days of the date the issuer should have discovered the delinquency;
- Maintain termination-of-coverage records in accordance with Exchange standards; and
- Comply with the rules for effective dates of termination of coverage.

3.12.1 CMS Review Methodology

CMS reviewed QHP issuers' termination-of-coverage written policies to determine if the policies contained the required elements, and to determine that terminations were made only for reasons permitted under the Exchange rules. CMS also performed testing on a sample of enrollee termination notices from each QHP issuer to determine if enrollees were notified of their terminations promptly and 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 and 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.

3.12.2 Results

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

Table 12: Termination of Coverage Findings or Observations¹⁸

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ Termination-of-coverage policy is not complete.	3	N/A ⁹
	▪ Enrollees receiving APTC were not provided three consecutive month grace period.	2	N/A ⁹
	▪ Termination notices did not include the effective date for termination.	3	N/A ⁹
	▪ Delinquency notices were not provided to the enrollee.	9	N/A ⁹

¹⁸ There were 34 findings in this area for 18 out of 21 QHP issuers reviewed because several QHP issuers had multiple findings. Eighteen QHP issuers received at least one finding in this review area; 3 received none.

Review Methodology	Findings or Observations	Findings Count	Observations Count
	<ul style="list-style-type: none"> Termination notices were processed for a reason not permitted under Exchange rules. 	0	N/A ⁹
	<ul style="list-style-type: none"> Termination notices were not sent to the enrollee. 	12	N/A ⁹
	<ul style="list-style-type: none"> Termination notices were not sent promptly, without undue delay. 	1	N/A ⁹
	<ul style="list-style-type: none"> Termination notices did not include the reason for termination. 	2	N/A ⁹
	<ul style="list-style-type: none"> Delinquency notices were not sent within 10 business days of the date the QHP issuer discovered the delinquency 	6	N/A ⁹
	<ul style="list-style-type: none"> Members had a rolling grace period. 	1	N/A ⁹

3.12.3 Best Practices

- Regularly review termination-of-coverage policy to ensure all standards for the termination of enrollment, including due to non-payment of 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 for all reasons of termination.

3.13 Renewal and re-enrollment notices

Pursuant to 45 C.F.R. § 156.1255, a QHP issuer is required to send Federal standard notices of product renewal and discontinuation to current enrollees as specified in 45 C.F.R. § 147.106 that includes the additional information specified in § 156.1255.

- A QHP issuer must provide each individual market policyholder with a written notice of renewal before the first day of the next annual open enrollment period (OEP).

3.13.1 CMS Review Methodology

CMS performed testing on a sample of enrollee renewal and discontinuances notices from each QHP issuer to determine if renewal or discontinuance notices are sent to enrollees completely, accurately and prior to open enrollment.

3.13.2 Results

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

Table 13: Renewal and re-enrollment notices Findings or Observations¹⁹

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	▪ Renewal/Discontinuance notices did not contain all the variable fields.	6	N/A ⁹
	▪ All variable fields were not completed appropriately.	2	N/A ⁹
	▪ Renewal/Discontinuance notice had an enrollee name mismatched.	0	N/A ⁹
	▪ Renewal notices did not contain 15 languages taglines.	0	2
	▪ Renewal/Discontinuance notices contained incorrect date format.	0	N/A ⁹
	▪ Renewal/Discontinuance notices contained incorrect plan year	1	N/A ⁹
	▪ Renewal/Discontinuance notices were not sent to the enrollee.	3	N/A ⁹
	▪ Renewal/Discontinuance used the incorrect model notice.	8	N/A ⁹
	▪ Renewal/Discontinuance notices were not sent in the appropriate timeframe.	2	N/A ⁹
	▪ Renewal/Discontinuance notices contained a date of January 15 for variable field 3.	1	N/A ⁹
	▪ Renewal/Discontinuance notices contained additional language to the model notice.	2	N/A ⁹
	▪ Renewal/Discontinuance notices produced using the incorrect plan year.	0	N/A ⁹
	▪ Renewal/Discontinuance notices did not follow the form and manner specified by the Updated Federal Standard Renewal and Product Discontinuation Notices.	2	N/A ⁹

3.13.1 Best Practices

- Ensure renewal or discontinuance notices are sent to the enrollee prior to the open enrollment period.
- Ensure the proper Federal standard notice is used, and all variable fields are completed correctly.

¹⁹ A total of 15 findings and observations in this area for 9 out of 21 QHP issuers reviewed are accurate as several QHP issuers had multiple findings and 9 QHP issuers received at least one finding in this review area.

3.14 Agent and Broker Oversight

Pursuant to 45 C.F.R. § 156.200(f), a QHP issuer must pay the same broker compensation for QHPs offered through an FFE that the QHP issuer pays for similar health plans offered in the State outside of an FFE.²⁰

Pursuant to 45 C.F.R. § 156.340(a)(2), a QHP issuer must confirm that their affiliated agents and brokers are compliant with all applicable regulatory requirements such as:

- FFE registration and training requirements.

3.14.1 CMS 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 2024 enrollments against the published *CMS Agent and Broker FFE Registration Completion List for Plan Year 2024* to determine if each affiliated agent or broker had completed the required FFE registration and training for PY 2024.²¹ CMS also compared the registration completion dates of those registered agents or brokers with the date of the first enrollment they assisted with for PY 2024 to determine if the QHP issuers' affiliated agents or brokers were assisting with enrollment prior to having completed the registration and training process.

3.14.2 Results

Table 14 lists findings or observations for this review area.

Table 14: Agent and Broker Oversight Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Agent and broker compensation is not consistent between on-Exchange and off-Exchange plans. 	0	7

3.14.3 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 for the applicable plan year, as required.
- Establish a process to educate affiliated agents and brokers if they are assisting consumers with FFE enrollments.

²⁰ In the 2018 Letter to Issuers Preamble, CMS states that in determining whether a plan offered outside the Marketplace is similar to a QHP offered through the FFE, CMS would consider factors such as whether the plan: has a similar cost-sharing and benefit structure; covers a majority of the same service area; and covers a majority of the same provider network compared to the QHP.

²¹ Available at <https://data.healthcare.gov/dataset/AB-Registration-Completion-List/wb6u-x2ny/data>.

- Establish a process to ensure agents and brokers are paid the same compensation for QHPs offered through the FFE that the QHP issuer pays for similar health plans offered off the FFE in that state.

3.15 Delegated and Downstream Entities

Pursuant to 45 C.F.R. § 156.340, a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities with all applicable Federal standards related to Exchanges. As part of these responsibilities, a QHP issuer must execute delegation agreements/amendments that in part: 1) specify delegated activities and reporting responsibilities; 2) provide for remedies if the delegated entity does not perform satisfactorily; and 3) otherwise conform with the requirements in 45 C.F.R. § 156.340(b).

3.15.1 CMS Review Methodology

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

- Specifies the delegated activities and reporting responsibilities;
- Provides for revocation of the delegation and reporting standards or specifies other remedies when HHS or the QHP issuer determines that the downstream or delegated entity has not performed satisfactorily;
- Requires compliance with all applicable statutes and regulations relating to the standards specified under § 156.340(a);
- Provides for access by HHS and the OIG or their designees, in connection with their right to evaluate through an audit, inspection, or other means, to the entity's books, contracts, computers, or other electronic systems relating to the QHP issuer's obligations in accordance with Federal standards under § 156.340(a) until 10 years from the final date of the agreement period; and
- Included 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.

3.15.2 Results

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

Table 15: Delegated and Downstream Entity Findings or Observations²²

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 the provisions required by 45 C.F.R. § 156.340. 	12	N/A ⁹

²² A total of 18 findings and observations) in this area for 17 out of 21 QHP issuers reviewed are accurate, as several QHP issuers had multiple findings and 17 issuers received at least one finding in this review area.

Review Methodology	Findings or Observations	Findings Count	Observations Count
	<ul style="list-style-type: none"> ▪ QHP issuer's downstream and delegated entity agreement (including any amendments thereto) contained general language about "compliance with all applicable laws."²³ 	0	1
	<ul style="list-style-type: none"> ▪ QHP issuer's downstream and delegated entity agreements did not contain the required Exchange-specific provisions under 45 C.F.R. 156.340(a) prior to January 1, 2015. 	0	0
	<ul style="list-style-type: none"> ▪ QHP issuer's downstream and delegated entity agreements did not contain the required Exchange-specific provisions under 45 C.F.R. 156.340(a) when the agreement was initially effectuated. 	0	5

3.15.3 Best Practices

- Review all agreements with downstream and delegated entities performing functions related to the FFEs to ensure that the provisions required under 45 C.F.R. § 156.340 are incorporated (as applicable).
- Establish oversight processes for downstream and delegated entities to ensure they are in compliance with their contractual obligations and applicable Exchange-specific requirements.

3.16 Maintenance of Records

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

3.16.1 CMS Review Methodology

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

²³ CMS notes as an observation that more specificity as to compliance with law is a best practice but not required under 45 C.F.R. § 156.340.

3.16.2 Results

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

Table 16: Maintenance of Records Findings or Observations²⁴

Review Methodology	Findings or Observations	Findings Count	Observations Count
Process Review	<ul style="list-style-type: none"> QHP issuer's written record retention schedule and policy did not reflect the required record retention timeframe. 	0	0
Performance Review	<ul style="list-style-type: none"> The QHP issuer failed to maintain records in accordance with requirements to maintain FFE records for a period of 10 years and to make available all records that are necessary for HHS to conduct financial audits and compliance reviews. 	6	N/A ⁹
	<ul style="list-style-type: none"> QHP issuer's termination notices were undeliverable and failed to retain notice. 	1	N/A ⁹

3.16.3 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.

3.17 Compliance Plans

Pursuant to 45 C.F.R. § 156.715, a QHP issuer subject to a compliance review by CMS 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 QHP certification standards, assess adherence to an effective compliance plan, and assess the likelihood of fraud or abuse.

3.17.1 CMS Review Methodology

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

²⁴ A total of 17 findings and observations in this area for 16 out of 21 QHP issuers reviewed are accurate, as several QHP issuers had multiple findings and 16 issuers received at least one finding in this review area.

3.17.2 Results

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

Table 17: Compliance Plan Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Failed to comply with record requests from HHS. 	0	0

3.17.3 Best Practices

- Create and regularly evaluate the compliance plan to help demonstrate that the organization has established procedures consistent with 45 C.F.R. § 155.1000(c), including an overall process to maintain compliance with each regulation and provide punitive and corrective actions should they be appropriate or required.
- Create policies and procedures to ensure records requested by CMS during a compliance review are submitted by the applicable deadline.

3.18 Casework

Pursuant to 45 C.F.R. § 156.1010, a QHP issuer must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS;²⁵
- Resolve non-urgent cases (for cases forwarded by HHS) no later than 15 calendar days after receipt of the case, and urgent cases no later than 72 hours after the case is received;
- Provide notice 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;²⁶ and
- Record resolution summaries in the HICS within 7 business days of completion with a clear and concise narrative of how the case was resolved.

3.18.1 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 internal HICS case notes, 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 manner; 4) a clear and concise narrative of how the case was resolved and

²⁵ 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.

²⁶ 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. See 45 C.F.R. § 156.1010(f)(1) and (2).

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.²⁷

3.18.2 Results

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

Table 18: Casework Findings or Observations²⁸

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> The complainant was not notified within 3 business days after the case was resolved. 	1	N/A ⁹
	<ul style="list-style-type: none"> HICS written notifications were not provided to the complainant. 	0	N/A ⁹
	<ul style="list-style-type: none"> Urgent cases were not resolved within 72 hours of receipt of the case. 	5	N/A ⁹
	<ul style="list-style-type: none"> Non-urgent cases were not resolved within 15 calendar days of receipt of the case. 	2	N/A ⁹
	<ul style="list-style-type: none"> HICS resolution summary did not contain how and when notification of the resolution was sent to the complainant. 	4	N/A ⁹
	<ul style="list-style-type: none"> Written notice informing complainant of case disposition was not provided to complainants in a timely manner for cases where the complainant was initially notified verbally of the case disposition.²⁹ 	2	N/A ⁹

3.18.3 Best Practices

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

3.19 Patient Safety Standards

Pursuant to 45 C.F.R. § 156.1110, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital meets the following patient safety standards:

- Utilized a patient safety evaluation system as defined in 42 C.F.R. § 3.20;

²⁷ For purposes of these compliance reviews, “timely manner” was considered to be within 2 weeks of the verbal notification, barring exceptional circumstances.

²⁸ A total of 17 findings and observations) recorded in this area for 10 out of 21 QHP issuers reviewed are accurate, as several QHP issuers had multiple findings and 10 QHP issuers received at least one finding in this review area.

²⁹ See supra note 17.

- Implementation of a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or
- Implementation 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.

3.19.1 CMS Review Methodology

CMS reviewed the QHP issuer’s policy or process to verify that contracted hospitals with more than 50 beds meet the required patient safety standards. If the QHP issuer does not have a policy or process in place to do so, CMS analyzes the hospital service contract to identify how the hospital demonstrates it meets the required patient safety standards.

3.19.2 Results

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

Table 19: Patient Safety Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> ▪ Patient safety standards were not met. 	0	0

3.19.3 Best Practices

- QHP issuer’s contracted hospital must utilize a patient safety evaluation system (a partnership with a Patient Safety Organization (PSO) or must implement an evidence-based initiative to improve health care quality.

3.20 Quality Rating System (QRS), Marketing Requirements

Pursuant to 45 C.F.R. § 156.1120(c), a QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS. Pursuant to 45 C.F.R. § 156.1125(c), a QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS. Pursuant to 45 C.F.R. § 156.1125(d), a QHP issuer must annually submit data necessary to conduct the survey to its contracted Enrollee Satisfaction Survey (ESS) vendor on a timeline and in a standardized form and manner specified by HHS.

3.20.1 CMS Review Methodology

CMS reviewed the QHP issuer’s website and other marketing materials to determine whether marketing materials reference the quality ratings for its QHPs and/or QHP Enrollee Survey results.

3.20.2 Results

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

Table 20: Quality Rating System, Marketing Requirements Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> QRS global rating inconsistent with Healthcare.gov. 	1	0

3.20.3 Best Practices

- Ensure the contracted hospital has a partnership with a PSO or has established an evidence-based initiative to improve health care quality.

3.21 Data Integrity for Certification of QHPs

Pursuant to 45 C.F.R. § 155.1000(c), a QHP issuer must provide evidence during the certification process in 45 C.F.R. § 155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156.

3.21.1 CMS Review Methodology

CMS reviewed the QHP issuer's policies or process documents that include verifying the accuracy of the data entered in the annual QHP certification templates and determining if the QHP issuers have a process for submission of data corrections due to data errors. Additionally, CMS reviewed the Change Analysis Report to determine if the QHP issuer had unapproved data changes during the current plan year.³⁰

3.21.2 Results

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

Table 21: Data Integrity for Certification of QHPs Findings or Observations

Review Methodology	Findings or Observations	Findings Count	Observations Count
Performance Testing	<ul style="list-style-type: none"> Data Integrity Tools (DIT) may not be used.³¹ 	0	1

3.21.3 Best Practices

- QHP issuers should use the DIT available during the QHP issuer certification process to ensure all data entered in the annual QHP certification templates is accurate.

³⁰ The Change Analysis Report identifies and summarizes what changed between a QHP issuer's previously approved plan submission and the current year's submission. It assists CMS in determining whether a plan's updates are minor administrative updates or material changes that require deeper review, correction, or denial.

³¹ The DIT is a pre-submission validation and quality assurance tool used by issuers, and it directly feeds into the Data Integrity findings CMS identifies during compliance reviews.

- Regularly review QHP issuer certification processes to ensure all changes are made in a timely manner.

4. CONCLUSION

CMS conducted FFE compliance reviews in PY 2024 for 21 QHP issuers representing 17 distinct parent companies in 14 FFE states. This included 18 individuals medical QHP issuers and 3 SADP issuers. All the reviews were completed through desk reviews.

Review areas that frequently included findings or observations included:

- Ensuring accurate and up-to-date provider directory information as required by 45 C.F.R. § 156.230(b)(2);
- Contract offers were not extended to Essential Community Providers (ECPs) and/or Indian Health Providers (IHPs) in good faith as required by 45 C.F.R. § 156.235;
- Ensuring that QHP issuer agreements with downstream and delegated entities meet the requirements of 45 C.F.R. § 156.340(b);
- Completing HICS casework as required by 45 C.F.R. § 156.1010, including recording outcomes and making appropriate notifications in a timely manner;
- Termination-of-coverage notices did not consistently meet the standards established by the FFE as required by 45 C.F.R. § 156.270;
- Incident and breach reporting process is not consistent with the QHP Certification Agreement and Privacy and Security Agreement as required by 45 C.F.R. § 156.265(c); and
- QHP renewal and/or discontinuation notifications did not meet Exchange requirements as required by 45 C.F.R. § 156.1255.

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2017 and 2024, 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.

APPENDIX – Finding or Observation Count by Review Area and De-Identified QHP Issuer

De-identified Issuer Information	Agent and Broker	API - Interoperability	Casework	Delegated Entity	Enrollment and Eligibility	Maintenance of Records	Meaningful Access	Network Adequacy: ECP	Network Adequacy: Provider Directory	Operations ³²	Patient Safety	Prescription Drug	Rate and Benefit	Renewal & Discontinuance	Termination of Coverage	Transparency in Coverage	Grand Total
2024-1	1			1	1	1			1			1		1	1		8
2024-2						1			1			1		1	2		6
2024-3	1			1				1	1			1		1	1		7
2024-4	1		1	2		1			1	1		1		1	1	1	11
2024-5			1	2	1				1			1		1	1		8
2024-6			1		2				1	1		1		1	2		9
2024-7				1		1		1	1			1		1	1		7
2024-8				1				1	1			1		1	1		6
2024-9	1			1				1	1			1	1	1	1		8
2024-10			1	1	1			1	1	1		1		2	1		10
2024-11					1			1	1					-	1		4
2024-12				1		1			1					-	1		4
2024-13	1		1	1					1			1		1	1	1	8
2024-14			1	1		1	1	1	1			1		-	1		8
2024-15		1		1					2	1	1	1		1	1		9
2024-16								1	1				1	1			4
2024-17								2	1				1	1			5
2024-18			1	1	1	1			1			1			1		7
2024-19	1			2				1	1					1			6
2024-20	1			1	1				1			1		1	2		8
2024-21			1	1	2				1						1		6
Grand Total	7	1	8	19	10	7	1	13	21	4	0	15	3	17	21	2	149

The chart above contains the actual count of each finding or observation recorded by 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 space constraints.

³² The Operations category was created to combine the elements of non-discrimination protected classes, compliance plan elements as noted in the *QHP Issuer Compliance Plan Organizational Chart*, and date integrity protocol area.