



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

**2016 Plan Year
Federally-facilitated Exchange
Issuer Compliance Review Summary Report**

December 8, 2017

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1. EXECUTIVE SUMMARY

In accordance with the Patient Protection and Affordable Care Act, as amended, and pursuant to 45 CFR 155.1010(a)(2) and 156.715, the Centers for Medicare & Medicaid Services (CMS) conducts qualified health plan (QHP) issuer oversight and compliance monitoring activities in Federally-facilitated Exchanges (FFE) including those in states performing plan management functions. Oversight and monitoring activities help protect consumers by ensuring issuers are compliant with applicable FFE standards. FFE compliance reviews also help issuers identify opportunities for improvement and provide insight to CMS on areas where additional guidance may be helpful.

This report summarizes the results from FFE compliance review activities related to plans certified for Plan Year (PY) 2016.¹ By sharing this report, CMS can provide insights on identified areas of non-compliance in 2016 and help issuers ensure their processes, procedures, and activities comply with CMS regulations and guidance.

Per 45 CFR 155.1010(a)(2) and 156.715, CMS may conduct compliance reviews of issuers offering QHPs, including stand-alone dental plans (SADPs), in the FFEs to ensure ongoing compliance with QHP certification standards and FFE requirements. CMS selected 30 issuer IDs from 18 FFE states, including 7 in which the states performed plan management functions,² for the compliance reviews of plans certified for PY 2016. The compliance reviews focused on issuer processes and operational testing related to the following areas: prescription drug benefits, QHP issuer participation standards, rate and benefits information, marketing and benefit design, network adequacy and Essential Community Providers (ECPs), meaningful access to health plan information, enrollment periods, enrollment processes for qualified individuals, termination of coverage for qualified individuals, issuer oversight of delegated and downstream entities including affiliated agents and brokers, health insurance casework system (HICS), rating variations, and compliance plans.

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

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

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

² The 7 FFE states in which the states performed plan management functions included in the PY 2016 compliance reviews were IA, IL, KS, ME, MI, NE, and OH. The 11 other FFE states included in the PY 2016 compliance reviews were AK, AZ, FL, GA, LA, NC, NJ, SC, TN, TX, and WI.

cases, a combination of findings or observations were discovered due to an issuer having problems with both its process and performance of a required activity.

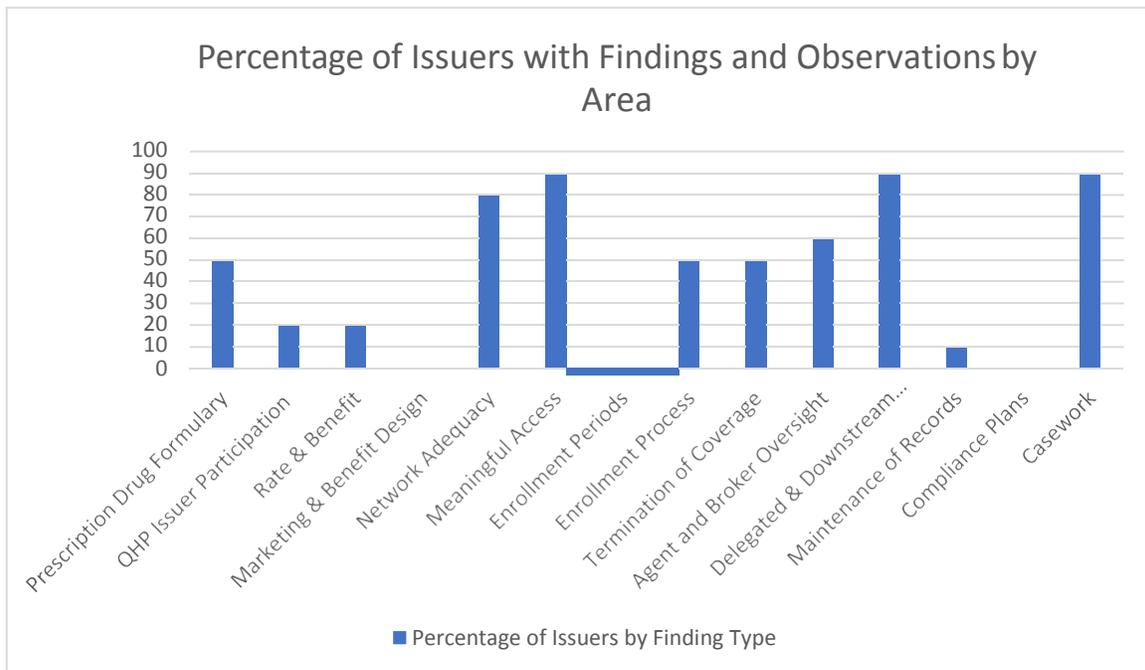
The following review areas were the most likely to produce findings or observations during the compliance review process:

- CMS identified issues regarding network adequacy including: Issuers did not make contract offers to ECPs and Indian health care providers as required by 45 CFR 156.235(a)(2)(ii), provider directories did not identify whether providers were accepting new patients and specific data elements were not up-to-date and accurate as required by 45 CFR 156.230(b), and issuers did not take action to ensure their provider networks conformed to their own internal network adequacy standards.³
- CMS identified issues with the timely resolution, documentation, and complainant notification of HICS casework as required by 45 CFR 156.1010.
- CMS identified issues with: 1) the timeliness or accuracy of notices sent to enrollees, or 2) issuer notices, websites, or published material did not include information in a manner compliant with accessibility and readability standards as required by 45 CFR 156.250 and 156.265.
- Reviews of issuers' downstream and delegated entity contracts identified that issuers did not include the Exchange-specific language as required by 45 CFR 156.340(b), and that there was inadequate monitoring of these entities (i.e., issuers did not confirm if affiliated agents and brokers completed the required FFE registration and training before assisting consumers).

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

³ Issuers identified as non-compliant with their internal standards were only subject to an observation, as this is not a regulatory requirement.

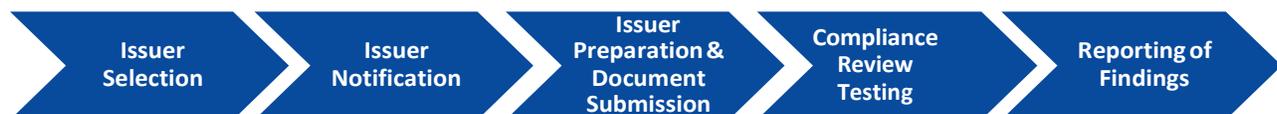
Figure 1: Percentage of Reviewed Issuers with Findings and Observations by Area



2. COMPLIANCE REVIEW PROCESS

Under 45 CFR 155.1010(a)(2) and 156.715, CMS has the authority to perform compliance reviews of issuers offering QHPs, including SADPs, in the FFEs to ensure ongoing compliance with requirements for QHP certification under 45 CFR Part 156 and other FFE standards. FFE compliance reviews may help issuers identify opportunities for improvement in meeting regulatory requirements and assist CMS in determining where additional guidance may be helpful. This section provides an overview of the compliance review process. A visual representation of the compliance review steps are depicted in Figure 2. CMS also released guidance in the form of the *Key Priorities for FFE Compliance Reviews for the 2016 Benefit Year*, which set forth a list of regulatory standards that CMS planned to include in the PY 2016 compliance reviews. This document is available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table.pdf.

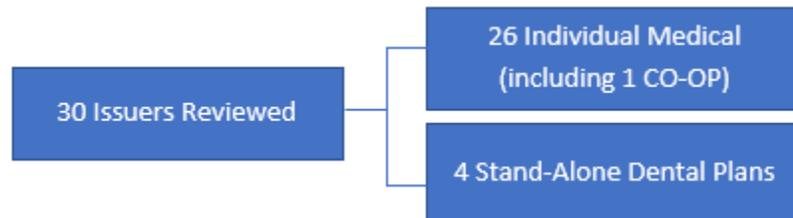
Figure 2: The FFE Compliance Review Process



CMS selects issuers for compliance reviews based on performance data and ongoing monitoring activities. For PY 2016, CMS conducted compliance reviews based on a selection of 30 issuer IDs. Beginning in March 2016, CMS issued notifications to the selected issuers and conducted kick-off calls to discuss each issuer’s selection and the compliance review process, and to inform the issuer of any documentation needed prior to start of the reviews. After receiving and reviewing the requested

documentation, CMS conducted interviews with each issuer's staff about its FFE operations. Figure 3 shows a breakdown of the issuer characteristics for PY 2016 compliance reviews.

Figure 3: Issuer Characteristics for PY 2016 Compliance Reviews



The PY 2016 compliance reviews consisted of 6 onsite reviews (encompassing 10 QHPs) and 20 desk reviews.⁴ During each review, CMS: 1) reviewed issuers' policies, procedures, and processes for all review areas within the scope of the review, and 2) performed testing for 11 of the 14 review areas to assess compliance with FFE regulations.

The next section details the results of the PY 2016 compliance reviews by review area. The PY 2016 compliance reviews focused increasingly on issuers' processes and performance, and less on their written policies and procedures, as compared to the PY 2015 compliance reviews. Written policies and procedures were still requested and reviewed as an aid for determining whether an issuer's processes and operations complied with FFE requirements.

3. COMPLIANCE REVIEW RESULTS

Findings or observations contained in this report align with the 14 review areas noted in the Executive Summary and associated regulatory standards. Tables 1 through 14 present findings or observations for each of the 14 review areas. Findings may result from discovery of evidence suggesting non-compliance, in addition to cases of confirmed non-compliance. Observations may result from discovery of evidence of potential non-compliance, in addition to identification of areas for improvement when there was no evidence of non-compliance.

CMS classified findings or observations⁵ based on the type of review methodology employed:

- **Process Review:** This included review of issuers' processes and procedures for review areas within the scope of the PY 2016 compliance review. Throughout the review, CMS requested and examined applicable policies and procedures established and provided by the issuer. This was completed primarily for informational purposes as most regulations do not require a written policy or procedure.
- **Performance Testing:** This included testing to assess issuers' compliance with FFE regulations for review areas within the scope of the PY 2016 compliance review. CMS completed testing

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

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

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 14 review areas, the methodology CMS used to review issuer compliance, any associated findings or observations, and suggested best practices for review areas that produced findings or observations.

3.1 Prescription Drug Formulary

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

- Covers at least the greater of one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan;
- Submits its formulary drug list to the Exchange, the State, or the Office of Personnel Management (OPM); and
- Has procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by its health plan.

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

3.1.1 CMS Review Methodology⁶

CMS reviewed prescription drug formularies available on the issuers' websites against those submitted as part of the PY 2016 QHP application process, to determine whether there were significant changes to the formularies since certification, which may be prohibited by non-discrimination requirements specified at 45 CFR 156.125 and 156.225(b).

3.1.2 Results

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

⁶The summaries of the CMS review methodology provided for the 14 review areas are not intended to represent the complete review process for each area of the review. They are intended as high-level summaries.

Table 1: Prescription Drug Formulary Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer’s online formulary omitted drug restriction requirements such as specific tier information. ▪ Issuer’s formulary design contained significant changes since certification. ▪ Changes to drug list appeared to go beyond mid-year maintenance updates to drug coverage.

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.

3.2 QHP Issuer Participation General Standards

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

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

3.2.1 CMS Review Methodology

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

3.2.2 Results

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

Table 2: QHP Issuer Participation General Standards Findings or Observations

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

3.2.3 Best Practices

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

3.3 Rating Variations

Pursuant to 45 CFR 156.210(c) and 156.255, a QHP issuer must comply with premium rate setting standards, including:

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

3.3.1 CMS Review Methodology

CMS reviewed FFE issuer websites to determine if the issuers posted rate increase justifications on their websites prior to implementation of rate increases.

3.3.2 Results

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

Table 3: Rating Variations Findings or Observations

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

3.3.3 Best Practices

- 1) Establish an annual process to ensure a justification is posted to its website consistent with Exchange regulations.

3.4 Marketing and Benefit Design

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

3.4.1 CMS Review Methodology

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

3.4.2 Results

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

Table 4: Marketing and Benefit Design Findings or Observations

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

3.4.3 Best Practices

- N/A

3.5 Network Adequacy

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

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

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

- Contract with at least the minimum percentage (i.e., 30% for PY 2016) specified by the Department of Health and Human Services (HHS) of available ECPs in each plan’s service area to participate in the plan’s provider network, or meet the alternate ECP standard described in 45 CFR 156.235(b);
- Offer contracts in good faith to all available Indian health care providers in the service area; and
- Offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP in that category is available.

3.5.1 CMS Review Methodology

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

CMS accessed the issuers’ online provider directories and selected a sample of 25 providers from the various specialty groups. Each provider office in the sample was contacted to confirm that the demographic information published in the directory was up-to-date, accurate, and complete. The information gathered during this contact was documented and compared to the submitted provider directory record to confirm that the location, telephone number, specialty, medical group, institutional affiliations, and reported status of the provider as not accepting new patients were correct. In cases where the issuer also created a stand-alone hard copy directory, CMS determined if it was consistent with the online directory.

CMS' testing of this review area also included a comparison of issuers' ECP lists against the HHS 2016 Non-Exhaustive List of ECPs, to identify if there were any counties and/or specialties within issuers' services areas that did not meet the FFE requirements for ECPs. In those counties where issuers did not meet ECP requirements, CMS requested documentation that the issuers extended a good-faith offer to contract to all Indian health care providers within the issuers' service areas and at least one ECP provider in each category in each county in the issuers' service areas.

3.5.2 Results

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

Table 5: Network Adequacy Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer provider directories: <ul style="list-style-type: none"> ❖ Did not indicate whether providers were accepting new patients, and/or were incorrect or out-of-date (e.g., sampled providers were no longer in practice and/or had incorrect contact information). ❖ Network analytics reports, provider network audits, and other network accessibility analyses self-identified potential service areas with insufficient provider coverage. ▪ Issuer's ECP list did not meet all ECP contract offer requirements (e.g., Indian health care providers were not offered contracts for PY2016).

3.5.3 Best Practices

- Regularly review provider directories, and establish a process to ensure they are accurate, complete, and current.
- Create a process to evaluate network adequacy that includes procedures to remedy deficiencies that are identified.

3.6 Meaningful Access

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

3.6.1 CMS Review Methodology

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

3.6.2 Results

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

Table 6: Meaningful Access Findings or Observations

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

3.6.3 Best Practices

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

3.7 Enrollment Periods for Qualified Individuals

Pursuant to 45 CFR 156.260, issuers must:

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

3.7.1 CMS Review Methodology

CMS reviewed issuers' enrollment period policies and procedures.

3.7.2 Results

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

Table 7: Enrollment Process Findings or Observations

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

3.7.3 Best Practices

- N/A

3.8 Enrollment Process for Qualified Individuals

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

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

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

3.8.1 CMS Review Methodology

CMS reviewed enrollment processes, new enrollment packages, and processes for reconciling enrollment files with the FFEs. To evaluate issuer compliance with FFE privacy and security standards, CMS reviewed privacy and security policies, materials for privacy and security training provided to employees and delegated and/or downstream entities, and records of individuals who completed the training.

3.8.2 Results

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

Table 8: Enrollment Process Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer enrollment packages and notifications did not consistently include information critical for obtaining health insurance coverage or access to health care services through the issuer in a manner that was compliant with accessibility and readability standards.

3.8.3 Best Practices

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

3.9 Termination of Coverage for Qualified Individuals

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

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

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

3.9.1 CMS Review Methodology

CMS reviewed issuers' termination-of-coverage written policies to determine if the policies contained the required elements. CMS also performed testing on a sample of 25 enrollee termination notices from each issuer to determine if enrollees were notified of their terminations without undue delay, and the notices contained a termination date and the reasons for the terminations. Additionally, CMS performed a review of issuers' record maintenance policies specific to termination of coverage. CMS also conducted performance testing on payment delinquency notices to determine whether issuers sent them within appropriate timeframes.

3.9.2 Results

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

Table 9: Termination of Coverage Findings or Observations

Review Methodology	Findings or Observations
Process Review	<ul style="list-style-type: none"> ▪ No policy defining the issuer's process related to termination of coverage was established or the policy did not include all elements.
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer did not send termination-of-coverage notices to all enrollees or they were sent with undue delay. ▪ Termination-of-coverage notices did not include a reason for termination or an end date to enrollees' coverage.

3.9.3 Best Practices

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

3.10 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.

3.10.1 CMS Review Methodology

CMS reviewed policies and procedures related to agent/broker onboarding. CMS then cross-referenced issuers' submitted lists of National Producer Numbers (NPNs) for agents and brokers who assisted with PY 2016 enrollments against the published *CMS Agent and Broker FFE Registration Completion List for Plan Year 2016*⁷ to determine if each agent or broker had completed the required registration and training. CMS also compared the registration completion dates of those registered agents or brokers

⁷ Available at <https://data.healthcare.gov/dataset/AB-Registration-Completion-List/wb6u-x2ny> the reviews were completed using the most recent update available at the time of the review.

with the date of the first enrollment they assisted with for PY 2016, to determine if the agents or brokers were assisting with enrollment prior to having completed the registration and training process.

3.10.2 Results

Table 10 lists findings or observations for this review area.

Table 10: Agent and Broker Oversight Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ NPNs for affiliated agents, brokers, or agencies did not match CMS' records. ▪ Agents, brokers, or agencies did not meet the required registration and training standards for PY 2016 prior to assisting individuals with enrollment in the FFEs.

3.10.3 Best Practices

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

3.11 Delegated and Downstream Entities

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

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

3.11.1 CMS Review Methodology

CMS reviewed each contract or amendment with a delegated or downstream entity submitted by the FFE issuer to determine if the contract specifically:

- 1) Specifies the delegated activities and reporting responsibilities;
- 2) Provides for revocation of the delegation or other remedies when HHS or the QHP issuer determines that such parties have not performed satisfactorily;
- 3) Requires compliance with all applicable ACA statutes and regulations,
- 4) Provides for access by HHS or its designees to the entity's books, contracts, computers, or other systems relating to the QHP issuer's obligations until 10 years from the final date of the agreement; and
- 5) Contained these specifications 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.

3.11.2 Results

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

Table 11: Delegated and Downstream Entity Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer’s delegation agreements/amendments did not include the language required by 45 CFR 156.340. ▪ Issuer is not performing oversight of its downstream and delegated entities to ensure ongoing compliance with regulatory requirements.

3.11.3 Best Practices

- Review all contracts with downstream and delegated entities performing functions related to the FFEs to ensure that the requirements of 45 CFR 156.340 have been incorporated as applicable.
- Establish oversight processes for downstream and delegated entities to ensure that they are in compliance with their contractual obligations and related FFE requirements.

3.12 Maintenance of Records

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

3.12.1 CMS Review Methodology

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

Findings or observations related to this review area were identified due to some issuers failing to supply certain requested documents or notices that should have been maintained. This was confirmed when issuers communicated that requested documents were unavailable.

3.12.2 Results

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

Table 12: Maintenance of Records Findings or Observations

Review Methodology	Findings or Observations
Performance Testing	<ul style="list-style-type: none"> ▪ Issuer’s records were not available for submission to be reviewed. The issuer advised that the documents in question were unavailable; therefore, records were not retained as required.

3.12.3 Best Practices

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

3.13 Compliance Plans

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

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

3.13.1 CMS Review Methodology

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

3.13.2 Results

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

Table 13: Compliance Plan Findings or Observations

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

3.13.3 Best Practices

- N/A

3.14 Casework

Pursuant to 45 CFR 156.1010, FFE issuers must:

- Investigate and resolve, as appropriate, consumer cases forwarded by HHS⁸;
- 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 notice⁹ 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

⁸ CMS records casework in the Health Insurance Casework System (HICS), a web application that CMS requires issuers operating in FFEs to use for casework intake and resolution activities.

⁹ 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.

- Record resolution summaries in the HICS within 7 days of completion with a clear and concise explanation of the how the case was resolved.

3.14.1 CMS Review Methodology

CMS reviewed the casework documentation submitted by each issuer for 50 HICS cases selected by CMS for review. The submitted documentation included internal HICS case notes, resolution notices, written case narratives and screenshots of the resolution pages in HICS, and written case dispositions.

Each case record was tested to determine if: 1) the issuer resolved the complaint within the applicable non-urgent or urgent timeframe¹⁰; 2) the complainant was notified verbally or in writing within 3 business days of the resolution; 3) for complainants notified of the resolution verbally, written notice was also provided in a timely manner; 4) a clear and concise narrative of how the case was resolved and how and when the complainant was notified was documented in HICS; and 5) the resolution narrative was uploaded to the HICS system within 7 business days after resolution.

3.14.2 Results

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

Table 14: Casework Findings or Observations

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

3.14.3 Best Practices

- Regularly review casework processes to ensure cases are reviewed, researched, and resolved consistent with FFE regulations.

4. CONCLUSION

FFE compliance reviews in PY 2016 were conducted for 30 FFE issuers representing 23 distinct parent companies. This included 26 individual medical issuers (including one CO-OP) and four SADPs. Six of the reviews were completed onsite, and the remainder through remote communications.

Review areas that frequently included findings or observations included:

- Ensuring that affiliated agents and brokers have properly completed the registration process as required by 45 CFR 156.340(a)(3),

¹⁰ Urgent cases are required to be resolved within 72 hours of receipt and non-urgent cases are required to be resolved within 15 calendar days of receipt.

- Updating agreements with downstream and delegated entities to ensure their compliance with 45 CFR 156.340(b),
- Completing HICS casework as required by 45 CFR 156.1010, including recording outcomes and making appropriate notifications in a timely manner, and
- Notifying enrollees of their termination in a timely manner as required by 45 CFR 156.270.

The FFE compliance review process evolves annually to coincide with updates to regulations and guidance. Between 2015 and 2016, the primary change to the compliance review process consisted of an increased focus on testing operations as opposed to 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 influence future guidance and regulatory updates.