



# **2014 Plan Year Issuer Compliance Summary Report**

December 16, 2015

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## 1.0 Executive Summary

In alignment with the Patient Protection and Affordable Care Act, as amended, (ACA) and pursuant to 45 C.F.R. 155.1010(a)(2), the Centers for Medicare & Medicaid Services (CMS) conducts qualified health plan (QHP) issuer oversight and compliance monitoring activities in Federally-facilitated Marketplaces (FFMs).<sup>1</sup> These activities help protect consumers by ensuring issuers are compliant with FFM standards. FFM 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 and recommendations from two key compliance activities related to plans certified for plan years beginning between January 1, 2014, and December 31, 2014 (2014 plan years): 1) compliance reviews and 2) renewal and discontinuation notice reviews (notice reviews). By sharing this report, CMS can provide insights on identified areas of non-compliance in 2014 and help issuers ensure their policies, procedures, and consumer notices comply with CMS regulations and guidance.

### 1.1 Compliance Reviews

CMS selected 23 issuer IDs from 15 FFM states<sup>2</sup> for the compliance reviews of plans certified for 2014 plan years. The compliance reviews focused on issuer policies, procedures, and operational testing related to the following areas: casework review policies, issuer oversight of affiliated agent and broker compliance, delegated and downstream entities, enrollment periods for qualified individuals, enrollment process for qualified individuals, marketing and benefit design, health plan applications and notices, record retention, network adequacy standards, qualified health plan issuer participation standards, rating variations, termination of coverage for qualified individuals, and compliance plans.

The reviews found four types of results: operational, policy incomplete, policy not in effect, or no policy or procedure. Those results included “**findings**,” indicating discoveries of non-compliance related to a specific standard, for which a work plan is recommended, and “**observations**,” indicating discoveries of potential non-compliance, for which no work plan is recommended at this time.

Figure 1 displays the overall percent of issuers with **findings** of each type. Issuers often had multiple results in each area.

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<sup>1</sup> The FFM states from which CMS selected issuers for the reviews discussed in this report did not include states performing plan management functions in the FFMs, or states with state-based Marketplaces using the federal platform (SBM-FP).

<sup>2</sup> The 15 FFM states from which CMS selected issuers for compliance reviews of plans certified for 2014 plan years were: NJ, OK, TN, TX, ND, MO, SC, FL, AZ, MS, LA, GA, PA, WY, AK.

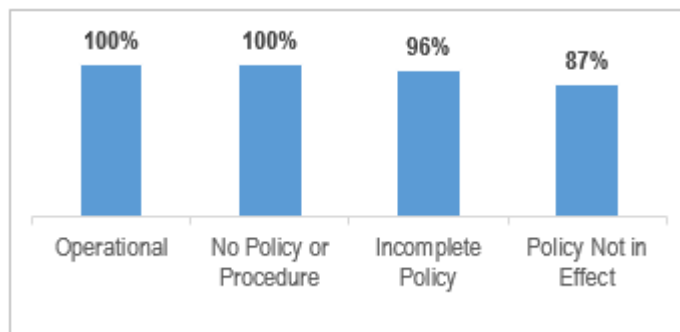


Figure 1. Overall Compliance Review Findings by Type

The most common type of **result** (including both findings and observations) was incomplete policies. For example, several policies excluded FFM-specific language and key provisions as outlined in FFM standards, and/or did not have the leadership signatures, approval dates, and effective dates required for a finalized policy. Often, issuer policies were not in effect for the entire plan year.

Many issuers did not have formal documented policies that addressed key standards. The types of policies that were found to be deficient in this way, included policies for verifying whether agents/brokers had completed all requirements and policies that explicitly outlined open enrollment periods, special enrollment periods (SEPs), and the circumstances that would trigger an SEP.

Finally, operational testing performed on key areas revealed opportunities for issuers to implement and maintain updated policies. The most frequently occurring results of operational testing were under the review area for agent/broker training records and comparison of National Producer Numbers (NPNs) against CMS records. Reviews revealed that many issuers did not confirm that their affiliated agents/brokers completed FFM training and registration requirements and NPNs in issuer documents often did not match CMS records. Section 5 provides a more detailed summary of the results and recommendations for each functional area.

Given the results noted in the findings and observations, CMS recommends issuers review the areas included in this report and use these insights to identify areas of improvement in their own policies and procedures. Since the good faith policy<sup>3</sup> will expire at the end of the 2015 calendar year, issuers are encouraged to have the appropriate policies and procedures in place. CMS expects issuers to be more familiar with FFM standards and processes and to have mechanisms in place to self-monitor compliance.

## 1.2 Notice Reviews

Under 45 CFR 147.106 and 156.1255, issuers renewing coverage or discontinuing a product including a QHP in the individual market must include certain information in the applicable renewal and discontinuance notices to their enrollees. Issuers are required to send renewal and product discontinuation notices in a form and manner that HHS specified in guidance in the June

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<sup>3</sup> 45 C.F.R. 156.800(c)

26, 2014, and September 2, 2014, bulletins.<sup>4</sup> **Figure 2** provides an overview of key review results.

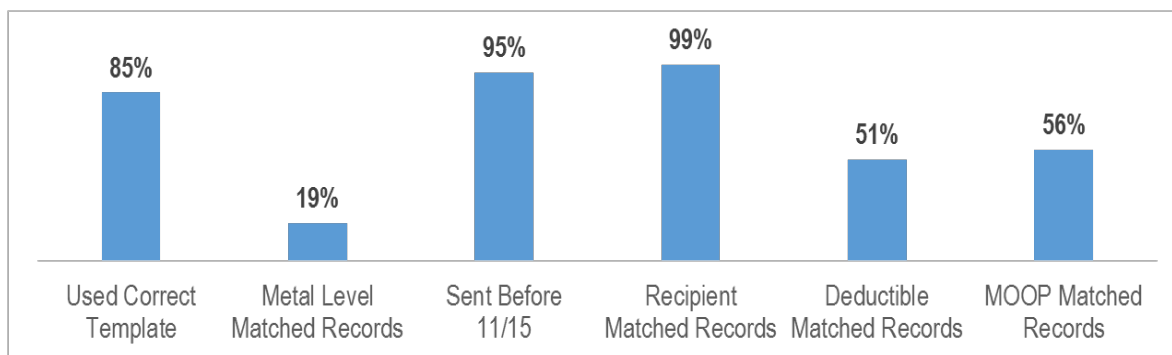


Figure 2. Overview of Select Notice Review Results

Issuers were generally compliant with the requirement to send to recipients notices that matched CMS records in a timely fashion. In contrast, most issuers did not accurately communicate metal level changes (e.g., from silver to bronze) to affected consumers. Review of notice contents revealed an additional opportunity for issuers to include accurate information about deductible, maximum out-of-pocket expenditure (MOOP), APTC, and premiums were included in either notices or supporting documents.

Issuer inclusion in notices of changes in cost sharing varied greatly. Those issuers who did not communicate metal level changes or cost-sharing changes often directed consumers to a generic website. These generic website links did not provide the consumer with information directly applicable to his or her QHP, but rather required the consumer to locate his or her QHP on the site then find the relevant changes. A complete summary of overarching notice review results and recommendations is located in **Section 4.0**.

Given these results, CMS recommends issuers review the areas included in this report and use these insights to identify areas of improvement in the notices and supporting documentation provided to consumers.

## 2.0 Compliance Review Process

CMS conducts compliance reviews of issuers to ensure compliance with FFM-specific standards, as outlined in 45 CFR 156.715. FFM compliance reviews can also help issuers identify opportunities for improvement, and assist CMS in determining where additional guidance may be helpful. The 2014 FFM compliance reviews focused on specific areas of the issuers' participation and activities in FFMs.<sup>5</sup> This section of the report provides a high-level overview of the review process (**Figure 3**).

<sup>4</sup> These bulletins are posted at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Bulletin-on-Renewal-and-Termination-Notices-FINAL.pdf> and <https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/renewal-notices-9-3-14-final.pdf>, respectively.

<sup>5</sup> Source: Key Priorities for FFM Compliance Reviews for the 2014 Benefit Year, available online at: [https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance\\_Review\\_Table\\_032814\\_508.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032814_508.pdf)

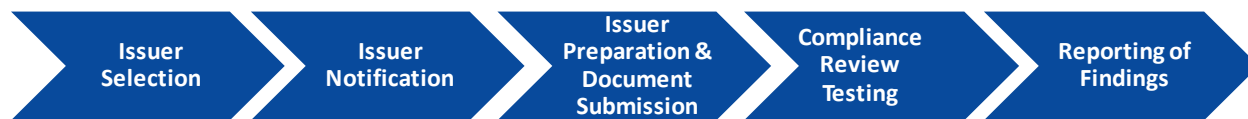


Figure 3. The FFM Compliance Review Process

CMS selects issuers for review based on available performance data and results of ongoing monitoring activities. For 2014 plan years, CMS conducted compliance reviews of 23 unique issuer IDs, 21 of which were selected by CMS, and two of which volunteered for the review process. **Figure 4** illustrates the issuer demographics for the 2014 reviews.



Figure 4. Overview of Issuers Reviewed in 2014

Beginning in April of 2014, CMS conducted kick-off calls with the selected issuers to notify them of their selection for 2014 FFM compliance reviews, discuss the compliance review process, and inform them of the documents that they had to submit to CMS. Once the documents were submitted, CMS reviewed them and conducted interviews with issuer staff on their FFM operations.

The 2014 compliance reviews included nine on-site reviews and 14 remote desk reviews.<sup>6</sup> During the review, CMS: 1) analyzed policies and procedures for comparison against FFM-specific standards and 2) conducted operational testing on documents and data provided by issuers to determine compliance with the appropriate FFM standards. Compliance review results were summarized in individual reports, which will aid CMS in the development of:

- Issuer education and technical assistance (e.g., bulletins, webinars);
- Potential updates to existing regulations and guidance;
- Updated compliance protocols; and
- Policy and operations.

FFM compliance reviews also help issuers identify opportunities for improvement and provide insight to CMS on areas where additional guidance may be helpful. The following section contains the compliance review results and recommendations for issuers.

<sup>6</sup> Onsite reviews are conducted at the issuer’s facility. Desk reviews are conducted at remote office locations by telephone interviews, webinars, and e-mail. Review of documents is conducted in both types of reviews.

### 3.0 Compliance Review Results and Recommendations

This section contains a summary of the results and recommendations from the compliance reviews, which cover plans certified for 2014 plan years (plan years beginning between January 1, 2014 and December 31, 2014). For the 2014 and 2015 calendar years, CMS followed a good faith compliance policy to allow issuers additional time to meet new QHP requirements without enforcement action being taken if the issuer made good faith efforts to comply with applicable requirements. The results contained in this report are aligned with the functional areas and the associated regulatory standards, listed as findings or observations, and further categorized by type. **Figure 5** demonstrates this hierarchy.

The 13 functional areas under review included: casework, delegated/downstream entities (including affiliated agents/brokers), enrollment periods, enrollment process, health plan applications and notices, record retention, marketing and benefit design, network adequacy, issuer participation standards, rating variations, termination of coverage, and compliance plans.

Areas of concern or non-compliance found in the reviews are grouped based on necessary follow-up activities:

- **Finding** – Noted area of non-compliance with a particular regulation or requirement. For these issues, a work plan is recommended for resolution.
- **Observation** – A potential area of concern that may impact compliance but for which no work plan is recommended. Within each functional area, findings and observations are categorized by type. Each type is organized based on the following descriptions:
- **Policy or Procedure Findings and Observations** – Based on review of policy and/or procedures, organized into three groups:
  - **No Policy or Procedure** – Issuer has no documented policy or procedure in place to address the requirements.
  - **Incomplete Policy** – Issuer’s existing policy addresses only part of the requirements, does not indicate that it is applicable to QHPs offered through FFMs, exists in draft form, and/or excludes one or more of the following: author, origination date, the approver and approver’s title, the date of implementation, and the effective date or date reviewed/approved by management.
  - **Policy not in Effect** – Policy was not in effect for the QHP’s entire 2014 plan year.
- **Operational Findings and Observations** – Based on testing of processes or review of non-policy documentation (e.g., contracts, training records, notices).

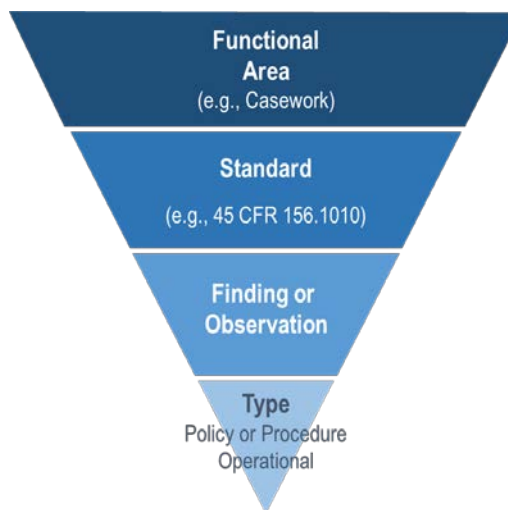


Figure 5. Results Organization



### 3.1 Results and Recommendations by Functional Area

Issuers offering QHPs in FFMs are required to follow standards specific to FFMs and related operations. CMS's review revealed 340 results across the 23 issuer IDs related to the standards that correspond to the 13 functional areas. CMS identified many areas where issuers had no formal policies or procedures, policies were incomplete or not FFM-specific, or were not in effect for the entire plan year. Additionally, CMS found a number of operational concerns where testing revealed that key processes were not in place or not followed. **Table 1** includes a list of overarching recommendations for issuers, based on lessons learned from the reviews. The rest of this section describes the standards that CMS requires issuers to follow (per 45 CFR 156), trends among findings and observations in each functional area, and recommendations for issuers. Appendix B (section 6.2) contains tables for each functional area that provide percentages of issuers with specific types of findings.

Table 1. Overarching Recommendations to Issuers

Area	Recommendations
Policy Readiness	<ul style="list-style-type: none"> <li>▪ Document new policies/procedures to properly reflect FFM standards and regularly monitor guidance to identify new areas for updates.</li> <li>▪ Finalize policies in advance of the plan year to ensure adequate time to communicate the change across the organization, adapt processes, and create consistency.</li> <li>▪ Include in all finalized policies appropriate management signatures, approval dates, and effective dates.</li> <li>▪ Check newly drafted or updated policies to ensure FFM-specific language is included as appropriate and that policies align to both state and federal Marketplace guidance and regulations.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate policy or procedure changes to staff early so that staff has adequate time to adapt.</li> <li>▪ Ensure policies are in effect for the entire plan year to maintain compliance.</li> </ul>
Internal Compliance Activities	<ul style="list-style-type: none"> <li>▪ Conduct routine checks to ensure that policies and procedures are effectively implemented across the organization.</li> <li>▪ Communicate policy, guidance, and process changes to employees early and often to maximize adaptation of practice.</li> </ul>

#### 3.1.1 Casework Review Policies

Issuers are required to investigate and resolve casework through their internal customer service process, and not through referral back to CMS, unless the case has been assigned to the issuer erroneously (e.g., the matter is entirely outside the issuer's control). Per 45 CFR 156.1010(d) and 45 CFR 156.1010(g), issuers must resolve non-urgent cases no later than 15 calendar days after receipt of the case, and urgent cases no later than 72 hours after the case is received. In all cases, issuers must document a resolution summary of the case no later than seven business days after resolution of the case. Issuers' policies and procedures must reflect these requirements.

To evaluate issuer compliance against these standards, CMS reviewed issuer policies for addressing casework through the Health Insurance Casework System (HICS). A summary of casework findings and recommendations to issuers is located in **Table 2**. Additional information is located in Appendix B.

Table 2. Casework Findings and Recommendations

Finding Type	Findings	Recommendations
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure for resolving HICS cases</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy to resolve HICS cases of varying levels of urgency.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate the process and timeframe for resolving HICS cases to staff.</li> <li>▪ Communicate policy or procedure changes to staff early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Formal policy lacks required language and procedures for checking HICS daily</li> <li>▪ Formal policy lacks clearly documented procedures and clear timeframes for resolving urgent or non-urgent HICS cases</li> <li>▪ Draft formal policy for resolving HICS cases has not been finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include in the casework policy, language and a process for checking HICS daily.</li> <li>▪ Check performance data on case resolution times regularly to monitor adherence to required timeframes and offer training and performance support to staff as needed.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Policy for resolving HICS cases not in effect for QHP's full 2014 plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each plan year to ensure compliance.</li> </ul>

### 3.1.2 Issuer Oversight of Affiliated Agent and Broker Compliance

To ensure compliance with 45 CFR 156.340(a)(3), issuers are required to confirm that their affiliated agents/brokers:

- Satisfy applicable FFM registration and training requirements;
- Maintain licensure and good standing in each state in which the agent/broker operates;
- Execute the FFM Privacy/Security Agreement and (if applicable) the General Marketplace Agreement; and
- Use the required disclaimers if an agent/broker non-FFM website is used to assist with QHP selection for enrollment through FFMs.

For this functional area, CMS reviewed policies and procedures related to agent/broker oversight and agent/broker agreements, cross-referenced the agent/broker National Producer Number (NPN) provided by issuers against CMS records, and reviewed procedures to verify whether affiliated agents/brokers completed FFM training and registration requirements. A summary of findings in this area and recommendations to issuers is located in **Table 3**. Additional information is located in Appendix B.

Table 3. Agent/Broker Standard Findings and Recommendations

Finding Type	Findings	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Not all issuers verified whether their affiliated agents/brokers completed FFM-required training (training certificates not available or incomplete)</li> <li>▪ NPN and/or names for affiliated agents, brokers, or agencies do not match CMS records</li> </ul>	<ul style="list-style-type: none"> <li>▪ Validate the FFM training and registration records for affiliated agents/brokers prior to allowing them to enroll consumers in FFM plans.</li> <li>▪ Collect and validate affiliated agent/broker NPNs and other contact information.</li> </ul>
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure for verifying affiliated agent/broker FFM registration prior to compensation</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain an oversight policy to ensure affiliated agents/brokers completed FFM registration requirements prior to compensation.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Proactively communicate requirements (and policy changes) to affiliated agents/brokers.</li> <li>▪ Communicate policy or procedure changes to staff early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Incomplete formal policy for verifying affiliated agent/broker FFM registration prior to compensation (lacks procedure to ensure verification)</li> <li>▪ Policy excludes required language on record retention</li> <li>▪ Draft formal policy for verifying affiliated agent/broker FFM registration prior to compensation not finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure the policy includes the actual process to verify affiliated agent/broker FFM registration and that this process is communicated to all affected stakeholders.</li> <li>▪ Retain FFM-related records for 10 years; include this requirement in the policy and ensure affected stakeholders are aware of it.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Policy for compensating affiliated agents/brokers not in effect for QHP's full 2014 plan year</li> <li>▪ Policies related to affiliated agent/broker oversight and agent/broker agreements not in effect for QHP's full 2014 plan year</li> <li>▪ Process for verifying that affiliated agents/brokers have completed FFM registration prior to compensation not followed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.3 Delegated and Downstream Entities

In addition to the above obligation related to affiliated agents/brokers, 45 CFR 156.340 states that issuers maintain responsibility for compliance of its delegated and downstream entities with applicable standards, such as:

- Ensuring issuer's delegated and downstream entities do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs; and
- Executing a delegation agreement that specifies the 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).

In this area, CMS reviewed policies and procedures for oversight of delegated and downstream entities. Additionally, delegation agreements (e.g., vendor contracts) were reviewed to determine whether they met key requirements, including:

- FFM-delegated and downstream entity contracts executed after October 1, 2013, included FFM-specific language;
- Vendor contracts included record retention language consistent with the 10-year FFM requirement; and
- Vendor contracts included language permitting HHS or its designee access to records to review them for compliance with ACA regulations.

A summary of delegated and downstream entity findings and recommendations for issuers is located in **Table 4**. Additional information is located in **Appendix B**.

Table 4. Delegated and Downstream Entity Findings and Recommendations

Finding Type	Findings	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Vendor contracts executed after October 1, 2013, do not contain FFM-specific language</li> <li>▪ Vendor contracts do not contain required language on record retention</li> <li>▪ Vendor contracts exclude language permitting HHS or its designee access to records to review them for compliance with the ACA regulations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure all vendor contracts adhere to standards by adopting template agreement that includes standard requirements.</li> <li>▪ Maintain templates as requirements evolve.</li> <li>▪ Ensure applicable staff has access to the latest templates.</li> </ul>
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure for delegation oversight</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain an oversight policy to ensure delegated/downstream entities meet requirements prior to compensation.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate requirements (and policy changes) proactively to all vendors/entities under contract.</li> <li>▪ Communicate policy or procedure changes to staff early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Oversight policy does not contain FFM-specific language</li> <li>▪ Policy excludes required language on record retention</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure the policy incorporates FFM-specific language; update policy as guidance evolves.</li> <li>▪ Retain FFM-related records for 10 years; include this requirement in the policy and ensure affected stakeholders are aware of it.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Policy for delegation oversight not in effect for QHP's full 2014 plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance</li> </ul>

### 3.1.4 Enrollment Periods for Qualified Individuals

Under 45 CFR 156.260, issuers must follow a defined enrollment process for the individual market by:

- Enrolling qualified individuals during the initial and subsequent annual open enrollment periods;

- Allowing for SEPs in cases of specific triggering events;
- Complying with the rules governing effective dates of coverage, as established by the FFMs; and
- Providing accurate communication of effective dates of coverage.

CMS reviewed issuer enrollment policies and procedures. A summary of findings and recommendations for issuers is located in **Table 5**. Additional information is in Appendix B.

Table 5. Enrollment Period Findings and Recommendations

Finding Type	Findings	Recommendations
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure that defines annual open enrollment periods and/or SEPs, or effective dates of coverage</li> <li>▪ Enrollment workflow is documented informally, but no formal policy exists</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy to define annual open enrollment periods, SEP timeframes and requirements, and effective coverage updates.</li> <li>▪ Monitor regulatory updates to ensure policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate these periods, requirements, and any changes to enrolled consumers, so they are aware of enrollment periods and impacts to their coverage.</li> <li>▪ Communicate policy or procedure changes early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Policy excludes documented process for completing enrollment in compliance with regulations</li> <li>▪ Policy excludes required language to fully address SEP requirements and triggering circumstances</li> <li>▪ Draft formal policy or procedures for special and/or open enrollment periods not finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Document the process for completing enrollment and include it in applicable policies; communicate this process to consumers and internal stakeholders.</li> <li>▪ Include open enrollment and SEP dates and requirements, as well as circumstances that trigger SEPs, in enrollment policies.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Policy and procedures for open and/or SEPs not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.5 Enrollment Process for Qualified Individuals

Under 45 CFR 156.265, issuers must adhere to the required enrollment processes for the individual market FFMs according to the following standards:

- Enroll a consumer through the FFMs only after receiving an eligibility determination from the FFMs;
- Comply with privacy and security standards applicable to safeguarding personally identifiable information (PII);
- Comply with rules regarding premium payments by individuals, Indian tribes, tribal organizations, and urban Indian organizations as well as premium payment rules regarding privacy and security; and
- Reconcile enrollment files with the FFMs not less than once a month.

While CMS reviewed issuers for compliance with 45 CFR 156.265 during 2014 plan years, issuers should be aware that 45 CFR 156.1250 became effective mid-2014 and requires issuers to

accept premium payments from certain third parties on behalf of enrollees. CMS will review issuers for compliance with this new regulation in future reviews.

To check issuer compliance, CMS reviewed enrollment policies and procedures, new enrollment packages, and FFM reconciliation policies and procedures. For privacy and security standards, CMS reviewed privacy and security policies, the privacy and security training materials provided to employees, as well as delegated and/or downstream entities, and records of individuals who took the training. A summary of results and recommendations to issuers is located in **Table 6**. Additional information is located in Appendix B.

Table 6. Enrollment Process Findings and Recommendations

Finding/Observation Type	Findings or Observations	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Failure to report security breach</li> </ul>	<ul style="list-style-type: none"> <li>▪ Handle any security breaches that affect over 500 consumers according to HIPAA protocol.</li> <li>▪ Report any security breach, regardless of the number of consumers affected, to CMS and the media as appropriate; breaches must be reported within 24 to 72 hours of the incident.</li> <li>▪ Implement policies and processes that protect the privacy and security of consumer PII/PHI.</li> <li>▪ Communicate these policies and processes to all staff who handle PII/PHI.</li> </ul>
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure that defines the enrollment process for FFM products</li> <li>▪ No formal policy exists that describes monthly reconciliation process for Advanced Premium Tax Credit/Cost Sharing Reduction (APTC/CSR) payments</li> <li>▪ No formal policy exists that describes payment of premiums from individuals or from third parties on behalf of qualified individuals</li> <li>▪ Enrollment workflow is documented informally; no formal policy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy to define the enrollment process for FFM products, a process for reconciling APTC/CSR payments, and the payment of premiums by third party payers.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate processes and rights to enrolled consumers as appropriate.</li> <li>▪ Communicate policy or procedure changes early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<p>Findings:</p> <ul style="list-style-type: none"> <li>▪ Policy for enrollment lacks clear process for reconciling APTC/CSR payments</li> <li>▪ Policy and procedures do not address accepting aggregated payment of premiums by third parties (e.g., Indian tribes, tribal organizations, urban Indian organizations, Ryan White organizations)</li> <li>▪ Policy for premium payment excludes language on accepting payments directly from individuals</li> <li>▪ Draft formal policy or procedures for enrollment process not finalized</li> </ul> <p>Observation:</p> <ul style="list-style-type: none"> <li>▪ Policy excludes documented process for completing enrollment in compliance with regulations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Document the enrollment process and include it the enrollment policy.</li> <li>▪ Communicate process and policy to both internal and external stakeholders as appropriate.</li> <li>▪ Train affected staff on the enrollment process, including payment processing and reconciliation.</li> <li>▪ Include in the enrollment policy a documented process for handling and reconciling APTC/CSR payments, and the process for receiving payments from individuals and aggregated payments by third parties.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>

Finding/Observation Type	Findings or Observations	Recommendations
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Policy and procedures for privacy and security in processing enrollment not in effect for QHP's full 2014 plan year</li> <li>▪ Policy that describes payment of premiums from individuals or from third parties on behalf of qualified individuals not in effect for full plan year</li> <li>▪ Policy that describes processing of APTC/ CSR payments not in effect for QHP's full 2014 plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.6 Health Plan Applications and Notices

Under 45 CFR 156.250, issuers must ensure the accessibility of health plan applications and notices. This includes making these documents accessible for individuals in accordance with the Americans with Disabilities Act (ADA) and for individuals with limited English proficiency.

To check compliance against this standard, CMS reviewed notifications sent to consumers. The findings and recommendations for issuers are located in **Table 7**. Additional information is located in Appendix B.

Table 7. Health Plan Application and Notices Findings and Recommendations

Finding Type	Findings	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Notices sent to enrollees omit required taglines for individuals with disabilities and/or limited English proficiency</li> </ul>	<ul style="list-style-type: none"> <li>▪ Create standard notice templates that adhere to CMS-issued guidance, including information about how individuals with a disability can access reasonable accommodations, and language taglines explaining how individuals with limited English proficiency can access language services.</li> <li>▪ Monitor regulations and guidance for updates to be applied to notice templates.</li> <li>▪ Educate staff responsible for creating notices on the requirements and ensure they have access to the most current template.</li> </ul>

### 3.1.7 Record Retention

Under 45 CFR 156.705, issuers are required to comply with the FFM standards for maintenance of records. This includes maintenance of FFM records for a period of 10 years.

CMS reviewed policies to determine issuer record retention schedules and compliance with the FFM-required 10-year maintenance period. A list of findings and recommendations for issuers is located in **Table 8**. Additional information is located in Appendix B.

Table 8. Record Retention Findings and Recommendations

Finding Type	Findings	Recommendations
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ FFM record retention schedule lacks required language regarding 10-year maintenance period or does not specify which documents are considered to be FFM records and are thus subject to the document retention policy</li> <li>▪ FFM record retention schedule not finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include in the policy the 10-year retention requirement for FFM records and monitor regulatory guidance for updates.</li> <li>▪ Communicate this policy with all staff who handle FFM-related records.</li> <li>▪ Include in policies appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ FFM record retention schedule not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.8 Marketing and Benefit Design

Under 45 CFR 156.225, issuers are not to employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in QHPs. These policies help ensure that all individuals belonging to protected classes are not discriminated against.

CMS reviewed issuer non-discrimination policies and codes of conduct. A list of findings and recommendations for issuers is located in **Table 9**. Additional information is located in Appendix B.

Table 9. Marketing and Benefit Design Findings and Recommendations

Finding Type	Findings	Recommendations
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Non-discrimination policies and/or code of conduct excludes language for self-reporting non-compliance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include all protected classes and individuals with significant health needs in non-discrimination policies.</li> <li>▪ Develop a process for staff to self-report non-compliance and include it in the code of conduct.</li> <li>▪ Educate employees and contracted entities on non-discrimination standards, processes for reporting non-compliance, and applicable non-retaliation policies.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Non-discrimination policy not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.9 Network Adequacy Standards

Under 45 CFR 156.230, issuers are required to maintain a sufficient provider network by adhering to the following standards:

- Ensure all services are accessible to all enrollees without unreasonable delay, consistent with the network adequacy provisions of section 2702(c) of the Public Health Service (PHS) Act;
- Maintain a network sufficient in number and types of providers, including mental health and substance abuse services;
- Publish a provider directory online and in hard copy upon request; and
- Identify providers that are not accepting new patients in the provider directory.

Under 45 CFR 156.235, QHP issuer networks must also have a sufficient number and geographic distribution of essential community providers (ECPs).



CMS reviewed provider directories and the policies and procedures issuers developed in order to create and maintain said directories. CMS also reviewed network accessibility documentation (e.g., GeoAccess, network lists, performance data) provided by issuers. A list of findings, observations, and recommendations for issuers is located in **Table 10**. Additional information is located in Appendix B.

Table 10. Network Adequacy Findings, Observations, and Recommendations

Finding/Observation Type	Findings or Observations	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Provider directory excludes date of most recent update</li> <li>▪ Provider directory excludes information on whether providers are accepting new patients</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include in directories the date of the most recent update, information on whether providers accept new patients, and providers with patient age restrictions.</li> <li>▪ Analyze provider networks regularly to proactively ensure reasonable access by enrollees.</li> </ul>
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure for accessing services from out-of-network providers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy on how and when consumers can access out-of-network providers.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Educate consumers on how and when to access out-of-network services.</li> <li>▪ Communicate policy or procedure changes early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<p>Findings:</p> <ul style="list-style-type: none"> <li>▪ Formal policy or procedures for maintaining provider directory excludes FFM-specific language</li> <li>▪ Formal policy excludes procedures for maintaining provider directory</li> <li>▪ Draft formal policy for maintaining provider directory not finalized</li> </ul> <p>Observations:</p> <ul style="list-style-type: none"> <li>▪ Network access policy submitted does not specifically include Marketplace products</li> <li>▪ Network access policy excludes language regarding out-of-network coverage</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include FFM-specific language in policies.</li> <li>▪ Network access policies should specifically include Marketplace products.</li> </ul>
Policy Not in Effect	<p>Findings:</p> <ul style="list-style-type: none"> <li>▪ Network access policy not in effect for QHP's full 2014 plan year</li> <li>▪ Procedures for monitoring network adequacy on ongoing basis are not in effect for full plan year</li> <li>▪ Process for maintaining provider directories is not in effect for full plan year</li> </ul> <p>Observations:</p> <ul style="list-style-type: none"> <li>▪ Out-of-network policy not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.10 QHP Issuer Participation Standards

Under 45 CFR 156.200, issuers are required to meet FFM participation standards. The standards require issuers to:

- Be certified by the FFMs for each health plan offered on an FFM;
- Comply with FFM processes, procedures, and requirements under Subpart K of 45 CFR Part 155 and, in the small group market, 45 CFR 155.705;
- Maintain licensure and good standing in each state in which it offers health insurance;
- Implement a quality improvement strategy, report quality and outcomes information, and implement appropriate enrollee satisfaction surveys;
- Offer at least one gold and one silver plan in an FFM, and child-only coverage options for each non-catastrophic QHP;
- Not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and
- Provide the same agent/broker compensation for similar coverage offered inside and outside the FFMs.

CMS reviewed non-discrimination policies, agent/broker compensation policies comparing on- and off-FFM coverage, and lists of all QHPs offered under the participating issuers' IDs. **Table 11** lists the findings and recommendations for issuers in this functional area. Additional information is located in Appendix B.

Table 11. Issuer Participation Findings, Observations, and Recommendations

Finding/Observation Type	Findings or Observations	Recommendations
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure on non-discrimination standards for FFM participation</li> <li>▪ No formal policy/code of conduct for self-reporting non-compliance with non-discrimination standards</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy for non-discrimination and process for self-reporting non-compliance.</li> <li>▪ Monitor regulatory guidance to ensure all protected classes are included in policies.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Communicate processes and rights to enrolled consumers as appropriate.</li> <li>▪ Communicate internal policy or procedure changes early so that staff has adequate time to adapt.</li> </ul>
Policy Incomplete	<p>Findings:</p> <ul style="list-style-type: none"> <li>▪ Non-discrimination policy excludes procedure for self-reporting</li> <li>▪ Non-discrimination policy excludes FFM-specific language</li> <li>▪ Non-discrimination policy excludes some protected classes</li> <li>▪ Draft formal non-discrimination and self-reporting policies not finalized</li> </ul> <p>Observation:</p> <ul style="list-style-type: none"> <li>▪ Quality improvement policy excludes FFM-specific language</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop a process for staff to self-report non-compliance and include it in the code of conduct.</li> <li>▪ Include all protected classes and individuals with significant health needs in non-discrimination policies.</li> <li>▪ Educate employees and contracted entities on non-discrimination standards, processes for reporting non-compliance, and applicable non-retaliation policies.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Non-discrimination policy not in effect for QHP's full 2014 plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.11 Rating Variations

Under 45 CFR 156.255, issuers are required to charge the same premium rate without regard to whether a plan is offered through an FFM, directly from the issuer, or through an agent. Issuers must:

- Demonstrate consistent application of premium variations by geographic rating areas; and
- Provide parity with respect to the cost of coverage offered inside and outside an FFM by charging the same premium rate without regard to whether the plan is offered through an FFM, directly from the issuer, or through an affiliated agent or broker.

CMS reviewed issuer premium rate setting policies. **Table 12** includes a summary of the findings and recommendations for issuers in this area. Additional information is located in Appendix B.

Table 12. Rating Variation Findings and Recommendations

Finding Type	Findings	Recommendations
Operational	<ul style="list-style-type: none"> <li>▪ Process for setting rates among similar products on or off FFMs is not followed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Charge the same premium rate for similar products sold on or off FFMs, through an affiliated agent or broker, or directly from the issuer.</li> <li>▪ Conduct testing when rates are set each year to validate parity of rates among similar plans on or off FFMs.</li> </ul>
No Policy or Procedure	<ul style="list-style-type: none"> <li>▪ No formal policy or procedure for setting premium rates among similar products on or off FFMs</li> <li>▪ Premium rate policy excludes procedure for ensuring the same rates for similar plans on or off the FFM</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop and maintain a formal policy and process to ensure the same rates for similar plans on and off FFMs.</li> <li>▪ Monitor regulatory updates to ensure the policy is compliant with current requirements.</li> <li>▪ Create an implementation plan for policies and procedures and monitor that plan.</li> <li>▪ Educate consumers about their rights regarding parity among rates.</li> <li>▪ Communicate this policy early to staff, so they have time to adapt their processes.</li> </ul>
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Premium rate policy excludes required language to ensure the same rates for similar products on and off FFMs</li> <li>▪ Formal policy for setting premium rates not finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Include in the policy, language on parity between rates for similar products on or off FFMs.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ Premium rate policy not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.12 Termination of Coverage for Qualified Individuals

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

- Terminate coverage only under certain permitted circumstances;
- Provide termination of coverage notices promptly to affected enrollees;
- Establish a policy for handling terminations of coverage due to nonpayment of premiums;

- Follow the special termination guidelines for recipients of APTC;
- Provide payment delinquency notices to affected enrollees;
- Maintain termination of coverage records in accordance with FFM-specific standards; and
- Comply with the rules for effective dates of termination of coverage.

CMS reviewed termination policies, procedures, and record retention policies and procedures specifically related to termination of coverage. **Table 13** summarizes the findings and recommendations for issuers in this area. Additional information is located in Appendix B.

Table 13. Termination of Coverage Findings

Finding Type	Findings	Recommendations
Policy Incomplete	<ul style="list-style-type: none"> <li>▪ Formal policy or procedure for terminating coverage excludes required language on all circumstances for termination of coverage</li> <li>▪ Formal policy or procedure for terminating coverage excludes required language on termination of coverage initiated by enrollee</li> <li>▪ FFM record retention schedule lacks required language regarding retaining termination of coverage files for 10 years</li> <li>▪ Formal policy or procedures for termination of coverage not finalized</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clearly delineate all possible circumstances for termination of coverage in the policy.</li> <li>▪ Clearly describe the process for handling termination of coverage when initiated by the enrollee.</li> <li>▪ Include in the policy, language regarding record retention consistent with FFM standards.</li> <li>▪ Retain all FFM records regarding termination of coverage for 10 years.</li> <li>▪ Educate staff on these policies to ensure consistency in how termination is handled and records are retained.</li> <li>▪ Include in policies, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Policy Not in Effect	<ul style="list-style-type: none"> <li>▪ FFM record retention schedule not in effect for full plan year</li> <li>▪ Formal policy or procedures for termination of coverage not in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure policies are effective at the beginning of each year to ensure compliance.</li> </ul>

### 3.1.13 Compliance Plans

Under 45 CFR 156.715, issuers are subject to compliance reviews and are required to provide CMS with full access to their records and facilities. While CMS reviewed each issuer's compliance plan (if available), establishing and maintaining a compliance plan was not a formal requirement for plan year 2014, and therefore findings are not noted in this area (only observations).

CMS reviewed compliance plans submitted by issuers. These plans illustrate issuers' commitment to compliance with FFM-related requirements. **Table 14** includes a summary of observations and recommendations for issuers regarding compliance plans. Additional information is located in Appendix B.

Table 14. Compliance Plan Observations and Recommendations

Observation Type	Observations	Recommendations
Plan Incomplete	<ul style="list-style-type: none"> <li>▪ Plan is missing numerous key elements of expected language and procedures</li> <li>▪ Plan is out of date and missing key language on privacy and security</li> <li>▪ Plan does not contain FFM-specific language for compliance practices</li> </ul>	<ul style="list-style-type: none"> <li>▪ Update compliance plans annually to ensure they address compliance with new requirements.</li> <li>▪ Include FFM-specific language and processes to protect consumer privacy and security.</li> <li>▪ Develop and document processes that will be used to regularly monitor against compliance standards and remediation process steps.</li> <li>▪ Educate staff on compliance processes, reporting, and applicable non-retaliation policies.</li> <li>▪ Regularly conduct internal compliance checks to monitor performance against key standards.</li> <li>▪ Include in compliance plan, appropriate management signatures, approval dates, and effective dates.</li> </ul>
Plan Not in Effect	<ul style="list-style-type: none"> <li>▪ Compliance plan has no effective date, so it cannot be verified to be in effect for full plan year</li> </ul>	<ul style="list-style-type: none"> <li>▪ Compliance plans should be in place and effective at the beginning of each year to ensure compliance.</li> </ul>

## 4.0 Renewal and Discontinuation Notice Reviews

Another key monitoring activity in the CMS compliance lifecycle is the review of QHP renewal and discontinuation notices. Under 45 CFR 147.106 and 156.1255, issuers renewing coverage or discontinuing a product including a QHP in the individual market must include certain information in the applicable renewal and discontinuance notices to their enrollees. Issuers are required to send renewal and product discontinuation notices in a form and manner that HHS specified in guidance in the June 26, 2014, and September 2, 2014, bulletins. The bulletins included templates with fields and information to inform consumers of their changes for the next plan year. CMS reviewed notices and supporting documents that issuers provided to consumers to assess application of templates and whether changes communicated matched CMS records. This section provides an overview of the reviews, their results, and recommended best practices for issuers to maintain compliance with FFM-specific standards.

### 4.1 Issuer Selection and Review Method

Approximately 1,157 notices were reviewed, representing 42 issuers in the FFMs, and including renewal notices and notices of discontinuance of a product including QHPs.<sup>7</sup> Issuers were identified based on the types of changes anticipated after the plan year, and final selection was sampled from that pool.

CMS requested renewal or discontinuation notices and supporting documents that were provided to the consumers. CMS reviewed the notices and supplemental documentation for adherence to HHS guidance, and evaluated the information communicated in the notices, including changes to metal level, deductible, MOOP, and benefits.

<sup>7</sup> Review excluded stand-alone dental plans (SADPs) and Multi-State Plans.

## 4.2 Notice Review Results and Recommendations

The following section provides an overview of the results for each area of review. The scope of the review included:

- General format and content of the notices;
- Timeliness in sending out notices;
- Accuracy of notice recipient; and
- Evaluation of deductible, MOOP, and cost-sharing changes for eight benefit types communicated in the notice.<sup>8</sup>

These areas of review were determined to be the most critical in ensuring consumers' access to care.

### 4.2.1 Notice Format and Content

Issuers renewing coverage or discontinuing a product must provide written notice in a form and manner specified by HHS. HHS specified the form and manner to be used in the June 26, and September 2, 2014, bulletins. Except for in states that develop and require issuers to use a different form that is at least as consumer-protective as the Federal standard notices, issuers in the individual market were required to use the Federal standard notices in the September 2, 2014, bulletin, and issuers in the small group market were permitted to use the draft Federal standard small group notices released in the June 26, 2014, bulletin, or any forms of the notice otherwise permitted by applicable laws and regulations.

Additionally, under 45 CFR 156.1255, issuers renewing coverage in the individual market FFMs must include certain information in their applicable renewal notices, including premium and APTC information. Per the September 2, 2014, bulletin, issuers must provide contact information for the consumer to call with questions and, in describing significant changes to the consumer's plan, issuers must specify in the notice whether the metal level of the consumer's plan changed. **Figure 6** illustrates overall findings related to notice format and content.

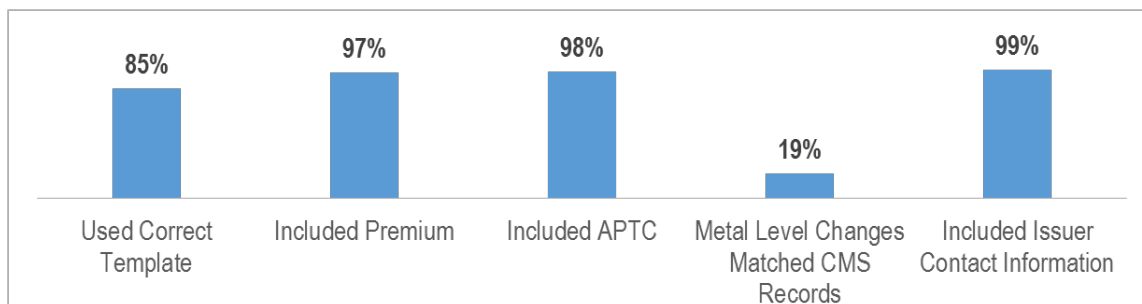


Figure 6. Notice Format and Content Review Results

As part of the July 26, 2014, and September 2, 2014, bulletins, CMS provided issuers with templates to use based on QHP status, meaning whether coverage was being renewed or the product including the QHP was being discontinued. Results showed 85% of the notices reviewed used the correct template in accordance with HHS guidance. Common among issuers that did not

<sup>8</sup> Eight benefits were reviewed: inpatient, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.

use the correct template was the practice of substituting the wrong template to convey a QHP’s status, or sending a renewal notice to discontinued consumers.

Additionally, 97% of consumer notices reviewed included premium amounts, and 98% included APTC amounts for eligible consumers.<sup>9</sup> While accuracy of either amount was not included in the review, one notice was found to list a negative premium amount on the notice. Some issuers directed consumers to a generic website link to locate their premium or APTC.

Nineteen percent of notifications communicating metal level changes to consumers were sent as a notice or as supporting documentation, which matched CMS records. Most issuers omitted this information from notices entirely. Eighteen notices from two issuers were found to communicate changes that did not match CMS records. For example, notices for one QHP incorrectly stated the new plan would be silver, rather than gold.

Finally, 99% of notices reviewed included issuer contact information. This element is key, should the consumer have a question or need to provide an update to the issuer. **Table 15** includes recommendations issuers should follow to ensure notices are formatted correctly and content aligns with CMS guidance for this area of review.

Table 15. Notice Format and Content Recommendations

Area	Recommendations
Notice Format and Attachment Type	<ul style="list-style-type: none"> <li>▪ Review the recommended attachment types per CMS guidance for renewals and product discontinuances and ensure notices are aligned correctly to limit consumer confusion.</li> <li>▪ Develop policies and procedures for creating notices in alignment with CMS guidance</li> <li>▪ Educate staff on guidance regarding notices.</li> <li>▪ Conduct quality batch testing on notices at the QHP and Variant ID level to ensure pertinent information required by the template is correctly populating.</li> </ul>
Notice Contents	<ul style="list-style-type: none"> <li>▪ Include the consumer’s correct plan name, metal level (and change from prior metal level, if applicable), premium, and APTC in the notice.</li> </ul>

### 4.2.2 Timeliness

Per the June 26, 2014, and September 2, 2014, bulletins, issuers must provide written notices to consumers in a timely manner.

- For renewal notices, before the first day of the open enrollment period.
- For discontinuation notices, at least 90 calendar days before the date the coverage will be discontinued. HHS stated that it would not take enforcement action against issuers that sent discontinuation notices on the same timeframe as renewal notices, and encouraged states to provide similar flexibility.

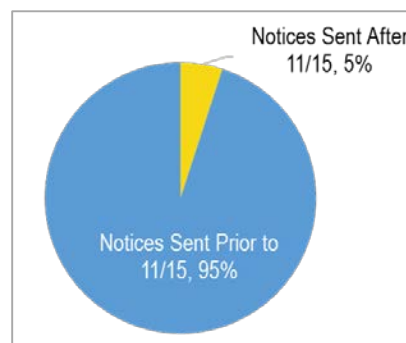


Figure 7. Timeliness of Notices

**Figure 7** shows the timeliness of notices. Five percent of notices reviewed were sent after Open Enrollment began.<sup>10</sup> On average, discontinuation notices were sent 30 days before

<sup>9</sup> Consumers not being enrolled into new plans were excluded from this analysis.

<sup>10</sup> Open Enrollment for plan year 2015 began on November 15, 2014.

Open Enrollment began, while renewal notices were sent 12 days prior to this date. Additionally, 6% of notices reviewed that were sent after Open Enrollment began were sent two weeks or more late. **Table 16** includes recommendations issuers should follow to ensure the timeliness of notices.

Table 16. Notice Timeliness Recommendations

Area	Recommendations
Renewal Notices	<ul style="list-style-type: none"> <li>▪ Send to consumers prior to the start of Open Enrollment.</li> </ul>
Discontinuation Notices	<ul style="list-style-type: none"> <li>▪ Send to consumers 90 days prior to the date of discontinuation.</li> </ul>

### 4.2.3 Notice Recipient

The regulations related to renewal and discontinuation notices require that issuers send written notices to all plan enrollees. Approximately 99% of notices that were sent to consumers enrolled through the FFMs match the enrollee names in CMS records. Some issuers sent notices to consumers with names that did not match CMS records (e.g., different last name, different full name, or truncated letters in last name). **Table 17** includes recommendations issuers should follow to ensure notices are sent to the correct recipient.

Table 17. Notice Recipient Recommendations

Area	Recommendations
Recipient Accuracy	<ul style="list-style-type: none"> <li>▪ Conduct quality assurance against enrollee records to ensure the correct names are listed in notices prior to sending them to consumers.</li> </ul>

### 4.2.4 Deductible and MOOP

Per the June 26, 2014, and September 2, 2014, bulletins, issuers must also include in the notice or supporting documents “significant changes to coverage, including but not limited to changes in deductibles, cost sharing, metal level changes, covered benefits, eligibility and provider network.” **Figure 8** illustrates an overview of trends related to communication of deductible and MOOP changes. Benefits are covered in the following section.

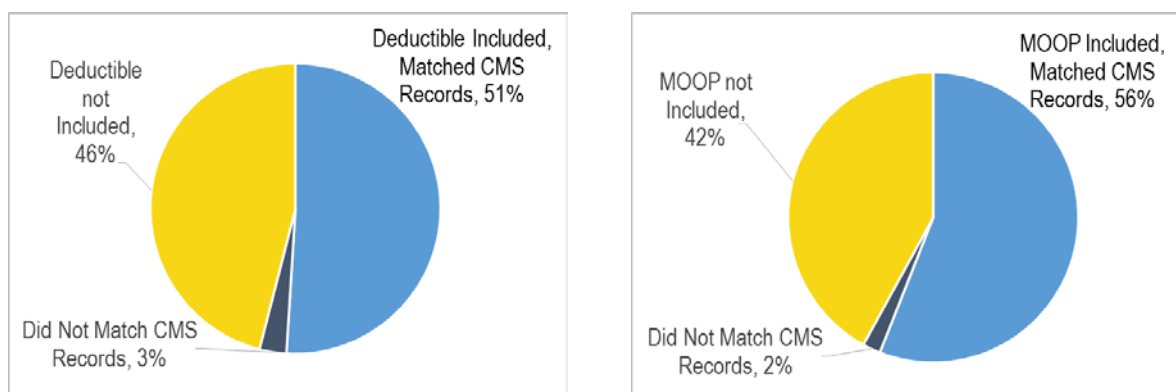


Figure 8. Communication of Deductible and MOOP Changes



CMS reviewed 394 notices for consumers affected by deductible changes. Of these notices, 51% communicated a change that matched CMS records and 3% communicated a change that did not match CMS records. The remaining notices either did not communicate the change to the consumer or directed the consumer to a generic website to locate changes to his or her plan.

CMS reviewed 527 notices for consumers affected by MOOP changes. Of these notices, 56% communicated a change that matched CMS records and 2% communicated a change that did not match CMS records. As with deductible, many consumers were directed to a generic website to locate changes to his or her plan. **Table 18** lists recommendations issuers should follow to ensure consumers receive adequate communication regarding deductible and MOOP changes.

Table 18. Notice Deductible and MOOP Recommendations

Area	Recommendations
<b>Validating Accuracy</b>	<ul style="list-style-type: none"> <li>▪ Crosscheck a sample of notices from each QHP offered against deductible and MOOP amounts for consumers, including consumers from different geographies.</li> </ul>
<b>Communication</b>	<ul style="list-style-type: none"> <li>▪ For consumers staying in the same plan, list clearly in notices or in a Summary of Benefits and Coverage (SBC) any changes to deductible or MOOP. (This does not apply to notices to consumers changing plans.)</li> <li>▪ Ensure that a website link directs the consumer to the location of his or her plan, if providing a link for additional information beyond those changes listed in the notice/SBC.</li> </ul>

### 4.2.5 Cost-Sharing Changes

For a subset of notices, CMS performed an in-depth review to determine if cost-sharing changes for eight benefit categories matched CMS records. The benefits for which cost-sharing changes were reviewed were: inpatient services, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.

CMS reviewed two types of cost-sharing changes for these eight benefits. The figures below illustrate the trends in two areas:

- **Cost-sharing structure changes (Figure 9)** - Consumer benefits are newly subject to (or no longer subject to) a deductible, copay, coinsurance, or switches between copay and coinsurance
- **Cost-sharing amount changes (Figure 10)** - Copay or coinsurance amount changes for each benefit

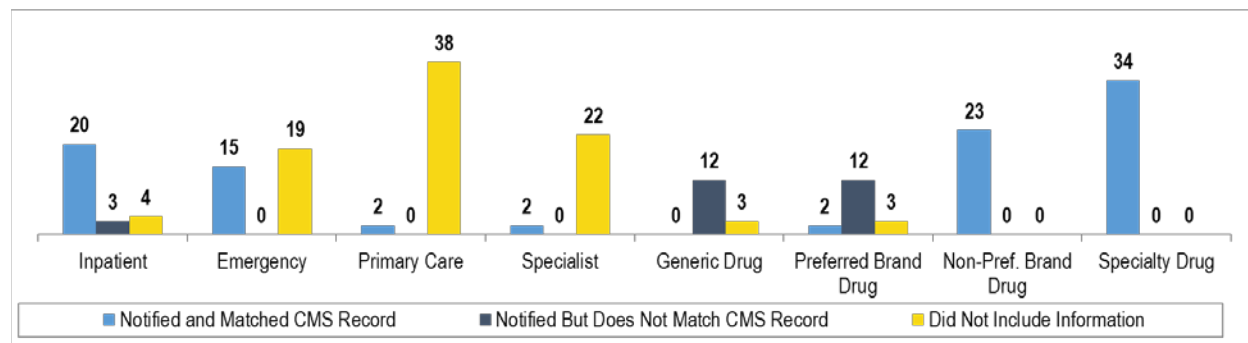


Figure 9. Consumer Notices Including Cost-Sharing Structure Changes

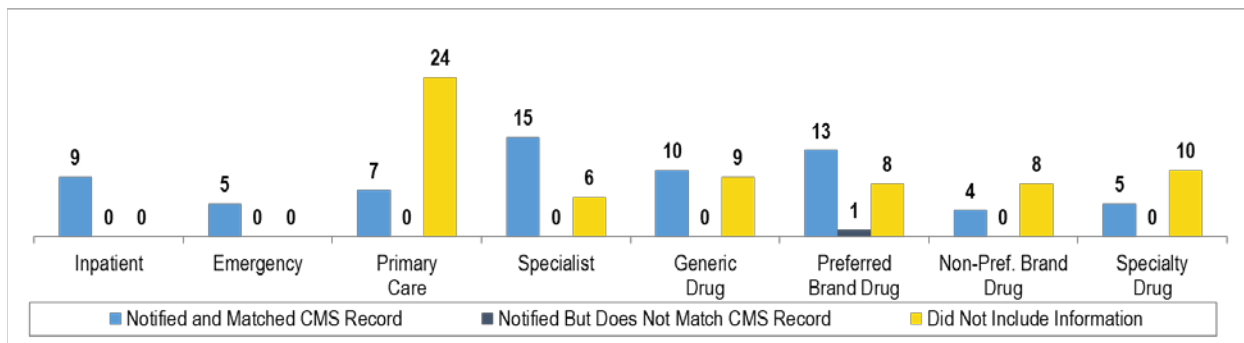


Figure 10. Consumer Notices Including Cost-Sharing Amount Changes

Issuers that did not communicate either of these types of changes often directed consumers to a generic website. These generic website links did not provide the consumer with information directly applicable to his or her QHP, but rather required the consumer to locate his or her QHP on the site and then find the relevant changes. **Table 19** lists recommendations issuers should follow to ensure consumers receive adequate communication regarding cost sharing.

Table 19. Notice Cost-Sharing Recommendations

Area	Recommendations
Validating Accuracy	<ul style="list-style-type: none"> <li>▪ Crosscheck a sample of notices from each QHP offered against cost-sharing amounts and structure for consumers, including consumers from different geographic areas.</li> </ul>
Communication	<ul style="list-style-type: none"> <li>▪ For consumers staying in the same plan, list clearly in an SBC any changes to benefit cost-sharing structure or amounts. (This does not apply to notices to consumers changing plans.)</li> <li>▪ Ensure that a website link directs the consumer to the location of his or her plan, if providing a link for additional information beyond those changes listed in the notice/SBC.</li> </ul>

## 5.0 Recommendations/Best Practices for Issuers

Results of the compliance reviews summarized above identify areas of improvement for issuer compliance with QHP certification standards. Issuers must ensure they comply with all standards at the time of certification and maintain compliance throughout the plan year. In addition, issuers maintain responsibility for compliance of its delegated and downstream entities (including affiliated agents and brokers). Future compliance reviews may focus on similar areas of review.<sup>11</sup>

Issuers are to ensure compliance with all QHP certification standards and FFM-specific requirements by integrating them into organizational policies and procedures and engraining them in day-do-day operations. As shown in the results, many issuers did not have policies in place, or had policies in place that were not fully compliant with the standards. To ensure future compliance, issuers should:

<sup>11</sup> For areas of review, refer to the Key Priorities document. The Key Priorities for 2015 are located online at the following link: [http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance\\_Review\\_Table\\_032715\\_508.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032715_508.pdf)

1. Review the standards and results described in this report and ensure they have complete and up-to-date policies and procedures that could demonstrate compliance with all FFM-specific standards;
2. Ensure those policies and procedures are being followed within their organization and are effectively implemented; and
3. Review each FFM-specific standard and if needed, contact their account managers for technical assistance and guidance.

If issuers become aware that they are non-compliant with the QHP certification standards or have not incorporated these requirements into their policies or procedures, they should:

1. Act immediately to address the deficiencies; and
2. If needed, contact their account managers for technical assistance and guidance.

All issuer policies and procedures that apply to FFM plans should incorporate all applicable FFM requirements. Several findings from the compliance reviews relate to having incomplete policies or no policy in effect. To help prevent this, issuers should:

1. Ensure that the policies and procedures contain the author, origination date, the approver and approver's title, the date of implementation, and the effective date or date reviewed/approved by management; and
2. Review every policy or procedure annually to ensure all new and existing standards are incorporated.

Under 45 CFR 156.715, CMS is able to evaluate any information concerning the issuer's compliance with QHP certification standards and FFM-specific standards. However, for the 2014 and 2015 calendar years, CMS is operating under a good faith policy to oversee and enforce issuer compliance with rules and regulations. Thus, the compliance review protocols are tailored to assess issuers' policies and procedures for consistency with and understanding of these requirements. Subsequent compliance reviews may incorporate review of other information under CMS's regulatory authority. The good faith policy expires at the end of the 2015 calendar year.

CMS will continue to provide guidance over the course of the year to assist issuers in developing and maintaining policies and procedures that comply with QHP certification standards and FFM-specific requirements. The results of these reviews and any updates to the overall compliance review process will be communicated to issuers via their account managers, upcoming webinars, and/or online materials.

## 6.0 Appendix

### 6.1 Appendix A. Program Areas and Standards Reviewed in 2014

This section contains a consolidated list of standards, aligned to each functional area, for compliance reviews, in addition to a listing of the focus areas covered in notice reviews.

Table 20. Standards Applicable to Each Functional Area for Compliance Reviews

Functional Area	Standard
Casework	45 CFR 156.1010(d) - Issuers in FFMs must resolve urgent cases no later than 72 hours after the case is received by the issuer and non-urgent cases no later than 15 calendar days after the case is received by the issuer.
	45 CFR 156.1010(g) - Issuers must document a resolution summary of the case no later than seven business days after resolution of the case.
Oversight of Affiliated Agents/Brokers	45 CFR 156.340(a)(3) - Issuers must ensure compliance by its affiliated agents/brokers, as downstream/delegated entities, in the following areas: 1) satisfying applicable FFM registration and training requirements, 2) maintaining licensure and good standing in each state in which the agent/broker operates, and 3) executing the applicable FFM Privacy/Security Agreement(s) and (if applicable) the General Marketplace Agreement.
Delegated and Downstream Entities	45 CFR 156.340 - Issuers must comply with standards related to delegated and downstream entities.
	45 CFR 156.340(b) - Issuers must ensure that a delegation agreement includes specified elements.
Enrollment Periods for Qualified Individuals	45 CFR 156.260 - The issuer must follow a defined enrollment process for the individual market by enrolling qualified individuals during the initial and subsequent annual open enrollment periods, allowing for special enrollment periods in cases of specific triggering events, and complying by the rules governing effective dates of coverage, as established by the FFMs.
Enrollment Process for Qualified Individuals	45 CFR 156.265 - Issuers must adhere to the required enrollment processes for the individual market in compliance with 45 CFR 156.265.
	45 CFR 156.265(b) - Issuers must adhere to the required enrollment processes for the individual market by enrolling a consumer through the FFMs only after receiving an eligibility determination from the FFMs.
	45 CFR 156.265(c) - Issuers must adhere to the required enrollment processes for the individual market by complying with privacy and security standards applicable to safeguarding enrollment information with respect to the personally identifiable information.
	45 CFR 156.265(d) - Issuers must adhere to the required enrollment processes for the individual market by complying with rules regarding premium payments by individuals and by Indian tribes, tribal organizations, and urban Indian organizations and well as premium payment rules regarding privacy and security.
	45 CFR 156.265 (f) - Issuers must adhere to the required enrollment processes for the individual market by reconciling enrollment files with the FFM not less than once a month.
QHP Issuer Participation Standards	45 CFR 156.200(b)(2) - Issuers must meet FFM-specific participation standards by complying with FFM processes, procedures, and requirements under Subpart K of 45 CFR Part 155.
	45 CFR 156.200(e) - Issuers must meet FFM-specific participation standards by not discriminating based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Marketing and Benefit Design	45 CFR 156.225(b) - Issuers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

Functional Area	Standard
Network Adequacy Standards	45 CFR 156.230(a) - Each issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, includes essential community providers in accordance with 156.235; maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.
	45 CFR 156.230(b) - Issuers must make a provider directory for a QHP available to the FFM for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, issuers must identify providers that are not accepting new patients.
Health Plan Applications and Notices	45 CFR 156.250 - Issuers must ensure the accessibility of Health Plan Application and Notices by making these documents accessible for individuals in accordance with the ADA and for individuals with limited English proficiency.
Rating Variations	45 CFR 155.255(a) - Issuers must demonstrate consistent application of premium variations by geographic rating areas.
	45 CFR 155.255(b) - Issuers charge the same premium rate without regard to whether the plan is offered through an FFM, directly from the issuer, or through an agent.
Termination of Coverage for Qualified Individuals	45 CFR 156.270(a) - Issuers must adhere to termination of coverage processes in the individual market by terminating coverage only under certain permitted circumstances.
	45 CFR 156.270(h) - Issuers must adhere to termination of coverage processes in the individual market by maintaining termination of coverage records in accordance with FFM-specific standards.
Record Retention	45 CFR 156.705 - Issuers must comply with the maintenance of records standards for FFMs.
Compliance Plans	45 CFR 156.715(a) - Issuers offering QHPs in an FFM may be subject to compliance reviews to ensure ongoing compliance with FFM-specific standards applicable to issuers offering QHPs in the FFMs
	45 CFR 156.715(b) - In preparation for or in the course of the compliance review, issuers must make available for HHS to review the records that pertain to their activities within the FFMs.
	45 CFR 156.715(b)(3) - In preparation for or in the course of the compliance review, issuers must make available for HHS to review the records of the issuer that pertain to their activities within the FFMs. Such records may include any other information reasonably necessary for HHS to evaluate issuer compliance with QHP certification standards and other FFM-specific standards applicable to issuers offering QHPs in the FFMs; evaluate the QHP's performance, including its adherence to an effective compliance plan, within the FFMs; verify that issuers have performed the duties attested to as part of the QHP certification process; and assess the likelihood of fraud or abuse.

Table 21. Areas of Focus for Renewal and Discontinuation Notice Reviews

Focus Area	Standards Used by Reviewers
Content	CMS Bulletin (September 2, 2014) - Notice of discontinuations and renewals is consistent with the federal standard notice exhibits and requirements (excluding student health insurance plans).
Deductible, MOOP, and Cost-Sharing Structure/ Amount Changes	CMS Bulletin (September 2, 2014) - Notice or supporting documentation communicates the changes in the consumer's coverage, including deductible, MOOP, and changes in benefit cost-sharing amounts and structure.
Timeliness	45 CFR 147.106(c) and (f); CMS Bulletin September 2, 2014 - Discontinuation or renewal notice was sent before November 15, 2014 (for benefit year 2015 only).
Recipient	45 CFR 147.106(c)(1); CMS Bulletin September 2, 2014; and General Guidance - Notice was sent to the correct consumer (ensuring consumers in a continuing plan received a renewal notice, and consumers in a plan under a product that was not going to be available in the market in 2015 received a discontinuation notice). Notice was sent to a current 2014 enrollee of the QHP referred to in the notice. Notice referred to the correct coverage type (individual versus family).

## 6.2 Appendix B. Additional Information on Compliance Review Findings

### 6.2.1 Casework Review Policies

**Figure 11** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type.

Sixty-one percent of issuers (i.e., 14 of 23) had incomplete policies. For example, many policies lacked specific language and processes for checking HICS daily and for resolving cases in a timely manner. Other policies excluded guidance on the timeframe for resolving HICS cases, or were still in draft form at the time of review. Nine percent of issuers (i.e., 2 of 23) did not have policies in effect for the entire plan year and 4% of issuers (i.e., 1 of 23) had no policy or procedure for resolving HICS cases.

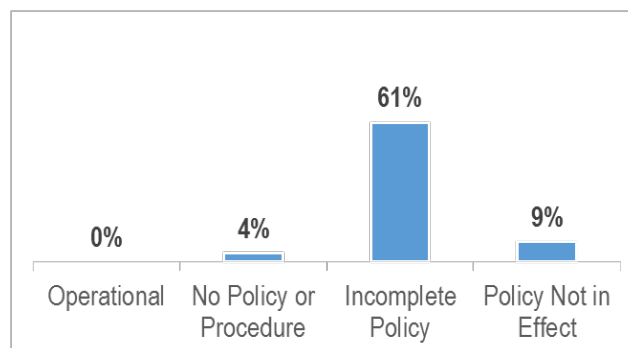


Figure 11. Issuers with Casework Findings

### 6.2.2 Issuer Oversight of Affiliated Agent and Broker Compliance

**Figure 12** provides an overview of the 63 findings in this area, specifically the percent of issuers that had findings of each type. All 23 issuers had findings related to oversight of affiliated agents/brokers, including some issuers with multiple findings.

Eighty-three percent of issuers (i.e., 19 of 23) did not have policies or procedures to verify that affiliated agents/brokers completed all FFM registration requirements prior to being compensated for enrollments through the FFMs. Seventy-eight percent of issuers (i.e., 18 of 23) had operational findings stemming from testing of NPNs or review of issuer procedures to verify FFM registration and training. A comparison of NPNs against the CCIIO registry revealed that provider NPNs often did not match CMS records, and review of issuer procedures found that issuers failed to consistently verify affiliated agents/brokers completion of all FFM registration requirements.

Additionally, 39% of issuers (i.e., 9 of 23) had incomplete policies (e.g., still in draft form, lacked required language on record retention, or excluded procedures to verify affiliated agent/broker FFM registration). Seventeen percent of issuers (i.e., 4 of 23) did not have policies related to affiliated agent/broker oversight and agent/broker agreements in effect for the entire plan year.

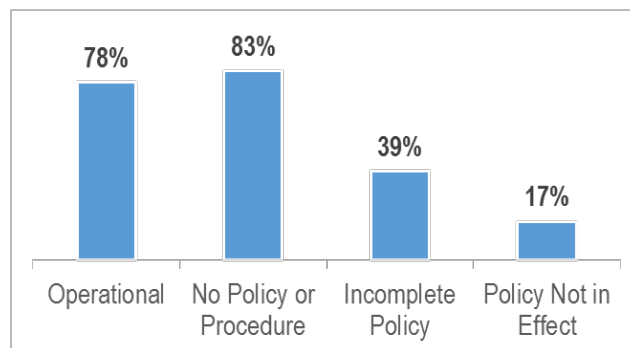


Figure 12. Issuers with Agent/Broker Findings

### 6.2.3 Delegated and Downstream Entities

**Figure 13** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type. Some issuers had more than one finding.

Sixty-one percent of issuers (i.e., 14 of 23) had operational findings regarding vendor contracts. Twenty-two percent of those issuers (i.e., 5 of 23) had incomplete policies (e.g., excluded FFM-specific language, guidance on record retention).

Seventeen percent of issuers (i.e., 4 of 23) had policies that were not in effect for the entire plan year and 4% of issuers (i.e., 1 of 23) had no formal policy or procedure for oversight of delegated or downstream entities.

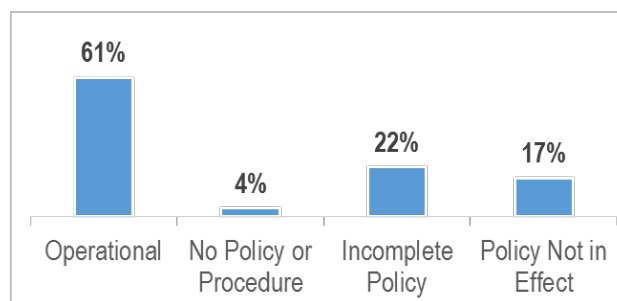


Figure 13. Issuers with Delegated and Downstream Entity Findings

### 6.2.4 Enrollment Periods for Qualified Individuals

**Figure 14** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type. Some issuers had multiple findings in this area.

Thirty-five percent of issuers (i.e., 8 of 23) demonstrated incomplete policies. For example, some issuers had policies in draft form at the time of review. Others lacked key aspects of the policy (e.g., required language on open enrollment periods and SEPs, circumstances triggering an SEP, or processes for managing the enrollment process in alignment with regulations).

Additionally, 35% of issuers (i.e., 8 of 23) had no formal policy or procedure to define annual open enrollment periods and/or SEPs, or effective dates of coverage. Some issuers had documented workflows to this effect, but formal policies did not exist at the time of review. Finally, 22% of issuers (i.e., 5 of 23) had policies not in effect for the full plan year. No issuers had operational findings.

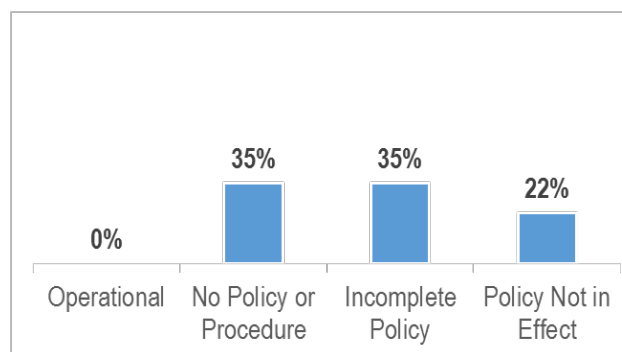


Figure 14. Issuers with Enrollment Period Findings

### 6.2.5 Enrollment Process for Qualified Individuals

Figure 15 shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type. Of the 21 issuers with findings, only two did not have multiple findings related to the enrollment process.

Seventy-four percent of issuers (i.e., 17 of 23) did not have formal policies or procedures. For example, some issuers were found to lack FFM-specific enrollment policies, policies on how to process and reconcile APTC/CSR payments, or policies on how payments may be accepted from third-party organizations. Additionally, 48% of issuers (i.e., 11 of 23) had incomplete policies;

some issuers had multiple findings of this type. For example, some policies insufficiently addressed processing or reconciling APTC/CSR payments. Other policies excluded language on accepting payments from individuals or from third parties on their behalf, or were still in draft form at the time of review.

Thirty-nine percent of issuers (i.e., 9 of 23) had policies not in effect for the entire plan year, including those related to protecting personally identifiable information (PII)/protected health information (PHI). The review further revealed one operational finding in this area where an issuer failed to report a security breach, highlighting privacy and security as an additional area of concern.

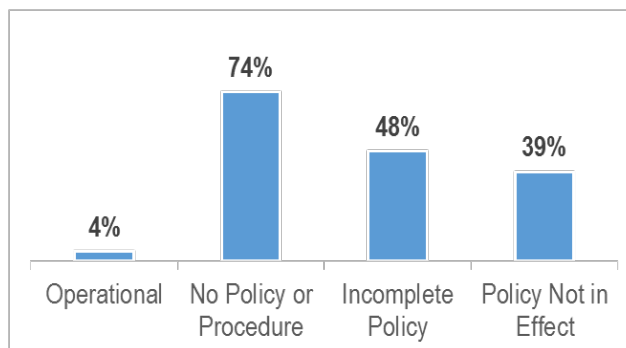


Figure 15. Issuers with Enrollment Process

### 6.2.6 Health Plan Applications and Notices

All findings identified by CMS were operational (**Figure 16**) and related to lack of required language taglines. Seventy percent of issuers (i.e., 16 of 23) excluded taglines about reasonable accommodations for individuals with disabilities and/or language services for individuals with limited English proficiency from notices. No issuers were found to lack policies or procedures, have incomplete policies, or have policies not in effect.

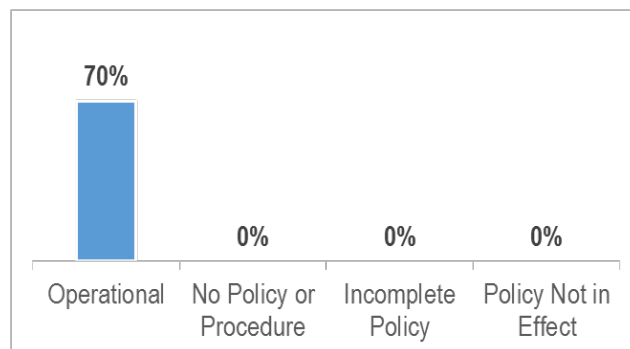


Figure 16. Issuers with Health Plan Application and Notice Findings

### 6.2.7 Record Retention

**Figure 17** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type.

Thirty-five percent of issuers (i.e., 8 of 23) had incomplete record retention policies. For example, policies were in draft form at the time of reviews, or lacked specific language related to FFM records or the 10-year retention requirement.

Additionally, 30% of issuers (i.e., 7 of 23) had record retention policies that were not in effect for the entire plan year. No issuers had operational findings or were found to lack policies or procedures.

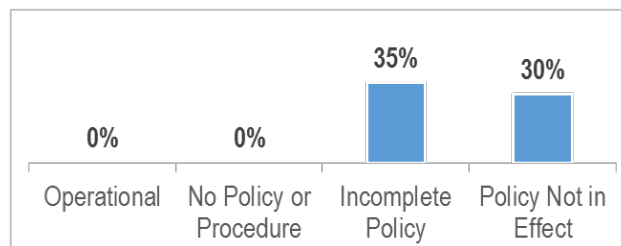


Figure 17. Issuers with Record Retention Findings



### 6.2.8 Marketing and Benefit Design

**Figure 18** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type.

Nine percent of issuers (i.e., 2 of 23) had incomplete policies. Specifically, non-discrimination policies excluded language on how employees should self-report non-compliance. Nine percent of issuers (i.e., 2 of 23) had non-discrimination policies not in effect for the entire plan year. No issuers had operational findings or were found to lack policies or procedures.

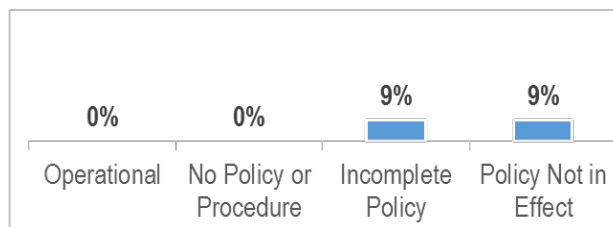


Figure 18. Issuers with Marketing and Benefit Design Findings

### 6.2.9 Network Adequacy Standards

Figure 19 shows an overview of the findings and observations this area, specifically the percent of issuers that had findings of each type. Of these issuers, all but four had more than one finding or observation in this area.

Forty-eight percent of issuers (i.e., 11 of 23) had policies not in effect for the entire plan year. Thirty-nine percent of issuers (i.e., 9 of 23) had incomplete policies. For example, some policies did not address out-of-network coverage, or lacked processes maintaining provider directories. Thirteen percent of issuers (i.e., 3 of 23) lacked out-of-network policies.

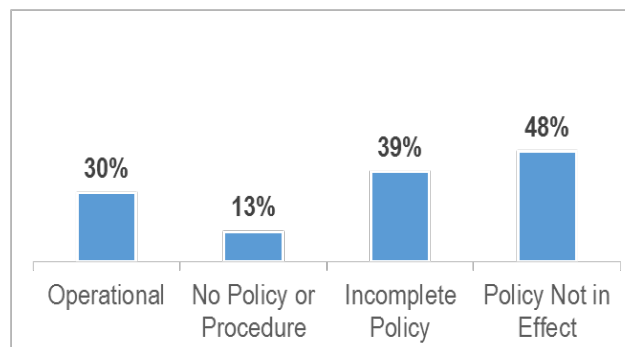


Figure 19. Issuers with Network Adequacy Findings or Observations

Finally, 30% of issuers (i.e., 7 of 23) demonstrated operational findings, which included findings of provider directory deficiencies and observations of issuer self-reported data on network access. Common themes among the findings related to provider directories included the exclusion of recent updates or clear delineation of which providers were accepting new patients. Some issuers also self-identified opportunities to improve network access.

## 6.2.10 QHP Issuer Participation Standards

**Figure 20** shows an overview of the findings and observations in this area, specifically the percent of issuers that had findings of each type.

Thirty percent of issuers (i.e., 7 of 23) had non-discrimination policies that were not in effect for the entire plan year. Additionally, 17% of issuers (i.e., 4 of 23) had incomplete policies. For example, some policies excluded FFM-specific language, while other policies were still in draft form at the time of review. Some issuers had policies that excluded procedures for self-reporting, or excluded certain protected classes of consumers. Several issuers had to revise non-discrimination policies to include all protected classes. Thirteen percent of issuers (i.e., 3 of 23) had no formal non-discrimination policies or codes of conduct regarding self-reporting non-compliance. No issuers had operational findings.

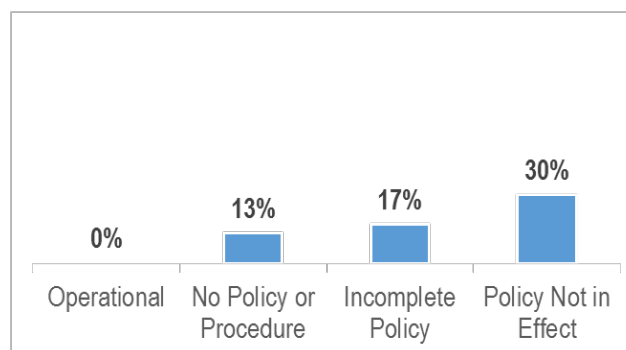


Figure 20. Issuers with Participation Standards Findings or Observations

## 6.2.11 Rating Variations

**Figure 21** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type.

Thirty-nine percent of issuers (i.e., 9 of 23) had policies for setting rates that were not in effect for the entire plan year. Seventeen percent of issuers (i.e., 4 of 23) had operational findings indicating they did not follow established processes for setting the same rate among similar products on or off the FFMs.

Seventeen percent of issuers (i.e., 4 of 23) did not have policies or procedures for establishing premium rates among similar products on and off the FFMs. Nine percent of issuers (i.e., 2 of 23) had incomplete policies (e.g., excluded language to ensure similar products on and off the FFMs were offered at the same rates, or were still in draft form at the time of review).

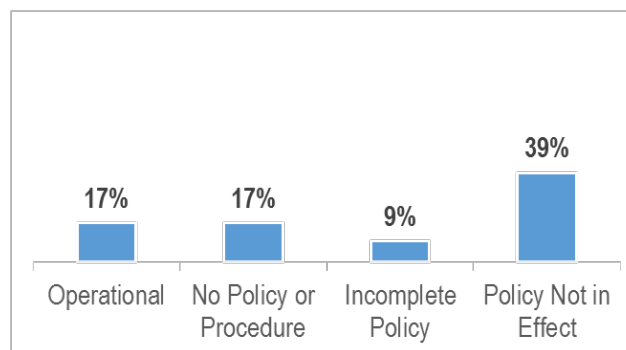


Figure 21. Issuers with Rating Variation Findings

### 6.2.12 Termination of Coverage for Qualified Individuals

**Figure 22** shows an overview of the findings in this area, specifically the percent of issuers that had findings of each type. Some issuers had more than one finding in this area.

Seventy percent of issuers (i.e., 16 of 23) had incomplete policies. For example, some issuers excluded language describing termination initiated by the enrollee, or failed to include other circumstances by which an enrollment could be terminated. Additionally, some issuer policies excluded record retention requirements for terminated enrollments. Thirty percent of issuers (i.e., 7 of 23) did not have policies in effect for the entire plan year. No issuers had operational findings.

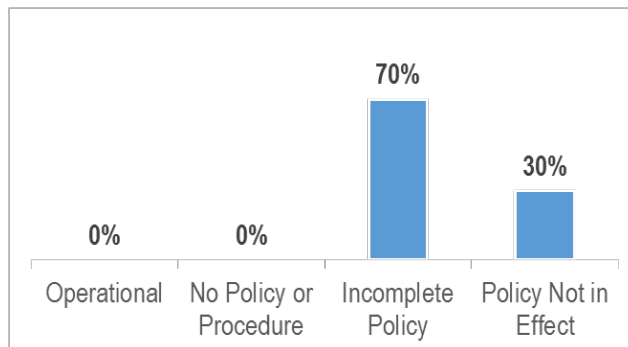


Figure 22. Issuers with Termination of Coverage Findings

### 6.2.13 Compliance Plans

**Figure 23** shows an overview of the observations in this area, specifically the percent of issuers that had observations of each type.

All observations were related to compliance plans being incomplete or not in effect for the entire plan year. Thirty percent of issuers (i.e., 7 of 23) had compliance plans not in effect and 22% (i.e., 5 of 23) had incomplete compliance plans. Common themes among the observations were a lack of FFM-specific language, or lack of protocols to protect the privacy and security of consumer information.

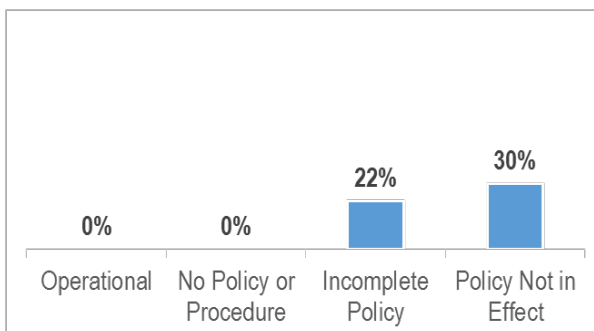


Figure 23. Issuers with Compliance Plan Observations