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How Effective is Your Health Insurance Exchange Compliance Program?

In 2014, health plans face a significant challenge – establish a rigorous health insurance exchange regulatory compliance program or risk potential financial losses down the line by 'getting it wrong'.

The advent of health insurance exchanges (HIX) presents a new level of regulatory complexity to health plans. Plans must adhere to an expansive set of federal and state-level health insurance exchange regulatory requirements, some of which are known, and many which will be evolving for some time. As a result, health plans should consider acting now to create a flexible and effective health insurance exchange regulatory infrastructure, one that will allow plans to rapidly deploy compliance solutions against an evolving regulatory landscape.

In today's healthcare landscape, deploying an effective compliance program should be a key aspiration for health plans. A strategic compliance program is one that manages the full scale of risk across business lines and the organization, eliminating silos and proactively addressing risk on multiple levels (e.g., reporting, security and privacy, etc.). Organizations that are successful apply an integrated approach to assessing and managing compliance risk, and delivering an organization wide response to prioritized risks.

In this article, we will describe:

1) Centers for Medicare and Medicaid Services (CMS) enforcement actions of compliance standards for health plans participating in the exchange marketplace
2) Key areas of compliance focus for qualified health plans (QHPs) on the Federally-Facilitated Marketplaces (FFM) and
3) Steps that plans should consider to build smart and comprehensive compliance programs

Many of the conclusions and viewpoints contained in this article are based upon the assumption that the FFM requirements will serve as the basis for audit and oversight protocols. Our expectation is that federal regulators will define and drive the standards, with the states following suit. We will also share our perspective on the characteristics that typically comprise an effective health insurance exchange compliance program and the key steps health plans will need to take to achieve that goal.

CMS will likely be an aggressive enforcer on the FFM. Plans will need to understand CMS protocols, processes and data sources related to health insurance exchange compliance.

In its 2015 Letter to Issuers in the FFM[1], CMS notes that it, "…will monitor compliance and evaluate performance using information received from various sources, including states, which may include: complaint data, issuer self-reporting of problems, information related to customer service and satisfaction, health care quality and outcomes, QHP issuer operations, and network adequacy."[2] Further, CMS notes that it will monitor operating performance of contracted entities to determine if they are in compliance with the exchange requirements. CMS will also target ineffective fraud, waste and abuse programs, as well as pushing the industry to become more adept in fraud prevention, implementing secret shopper programs, and using data analytics for targeted reviews.

[1] 2015 CMS Letter to issuers (Chapter 4, Page 37) - http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf

[2] 2015 CMS Letter to issuers (Chapter 4, Page 39) - http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf

Medicare and Medicaid compliance programs present an appropriate model and 'starting point' for health insurance exchange compliance.

In March of 2014,[3] CMS released its list of compliance priorities for QHPs operating in FFMs. These priorities are summarized in the table below. Though CMS noted that the list is not comprehensive, it provides an excellent guide for plans to prioritize their compliance needs in the first full year of FFM operation.

Of particular importance to note is the fact that many of the CMS priorities are shared with compliance standards and protocols contained in the Medicare Advantage and Part D programs. This may lead one to conclude that using government programs' compliance methods as a model may make good sense as CMS is likely to follow similar procedures with exchange enforcement. These "cross-over" areas are detailed in the table below:

	Summary of regulatory standards	FFM compliance priorities same/ different as Medicare regulations
QHP issuer participation standards	• Exchange certification for FFM • State licensure requirements • Gold/Silver plan offerings • FF-SHOP provisions • Quality improvement, outcomes and enrollment satisfaction reporting	Unique
QHP rate and benefit information	• Required submissions and posting of rate justifications prior to implementation	Unique
Marketing and benefit design	• Cannot discourage enrollment of those with significant health needs/adverse selection	Similar
Delegated and downstream entities	• Ensure that downstream entities do not discourage enrollment of those with significant health needs/adverse selection	Similar
Agent/broker standards	• Ensure compliance by agents and brokers in areas of training, registration, licensure, and privacy and security	Similar
Network adequacy standards	• Ensure access to services without unreasonable delay, and identify providers not accepting new patients • Provider directory online or hard copy	Same
Essential Community Providers (ECP)	• Ensure sufficient number and geographic distribution of ECPs • Appropriate reimbursement to federally qualified health centers	Unique
Health plan applications and notices	• Ensure readability and accessibility of plan documents according to American with Disabilities Act; also for limited english proficiency	Similar
Rating variations (cost variations)	• Must charge the same for plans regardless of means of purchase (exchange, agent, direct from issuer)	Similar
Enrollment periods for qualified individuals	• Must observe open enrollment, allow for life changes, comply with dates of effective coverage, follow pertinent rules of the exchange	Similar
Enrollment process for qualified individuals	• Must allow enrollment via the exchange as well as directly from issuer, must safeguard information, must reconcile enrollment files with the exchange at least monthly	Similar
Termination of coverage for qualified individuals	• Must terminate only in permitted circumstances, provide payment delinquency notices, establish policy for handling terminations due to nonpayment	Similar
Accreditation of QHP issuers	• Meet and maintain standards of a Health and Human Services (HHS) recognized accrediting entity • Accreditation timeline	Unique
Additional standards specific to FF-SHOP	• The FF-SHOP must comply with standards when accepting payments on behalf of a qualified employer or enrollee • Follow rate setting timelines, open and special enrollment and timelines, provision of enrollment information, notice of termination, etc.	Unique
Nonrenewal and decertification of QHPs	• Fulfill benefit coverage obligations to enrollees, reporting obligations to the exchange, and notify affected enrollees in a timely manner	Unique

[3] CMS Key Priorities for FFM Compliance Reviews - http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032814_508.pdf

CMS' stated priorities have several implications for health plans:

- Standards of participation will evolve and will likely become "more burdensome" over time; expect federal regulators to more rigorously enforce beneficiary protections, quality and the integrity of exchange-related programs.
- Plans will likely be held accountable for complete, accurate, and timely enrollment processing including beneficiary notifications, eligibility and effective dates.
- Similar to Medicare Advantage and Part D, plans will be required to maintain and reconcile beneficiary enrollment and eligibility status with the exchange, and do so while preserving the integrity of protected health information (PHI).
- The circumstances for terminating coverage with a beneficiary and the timeliness and accuracy of related communications will be an area of focus for regulators; maintaining records and the ability to demonstrate cause will be crucial.
- Not only will CMS hold plans accountable for compliance-compromising events committed by their contracted entities, they expect plans to have in place robust mechanisms to prevent those events from occurring in the first place. QHP compliance programs will need to extend deep into the operations of these delegated entities in order to demonstrate effectiveness to federal regulators.

An effective health insurance exchange compliance program combines a strong infrastructure with a focus on key program areas specified by regulators.

From the table above, we understand which areas are compliance priorities for CMS in the FFM marketplace. Beyond this list, it is important that health plans establish an overarching compliance program that meets the following requirements, as outlined by the Office of Inspector General (OIG) of the department of HHS:

- **Written policies and procedures should detail health plans' commitment to complying with federal and state standards**, as well as describe compliance expectations, and detail how potential compliance issues will be investigated and resolved.
- **If not already in place, plans should have a designated compliance officer and compliance committees.** The compliance officer and committees should be involved in daily compliance operations and identifying, identifying and investigating all compliance issues. Reasonable oversight by health plans must be exercised regarding the implementation and effectiveness of the compliance program.
- **Training and education programs should be established between the compliance officer and committee, the health plan employees, and downstream related entities.** At a minimum, these programs should be held annually.
- **Lines of communication established within the health plan should ensure confidentiality** between the compliance officer and the compliance committee, and allow for all compliance issues to be reported anonymously and in good faith.
- **A system for monitoring and auditing should include both internal and external audits** of the effectiveness of the compliance program, including first tier entities.
- **The enforcement of well publicized policies and procedures should include a system for promptly responding to compliance issues as they are identified.** Health plans should establish procedures for voluntarily self-reporting potential fraud or misconduct. Issues should be identified through a series of self-assessments within the health plan, as well as through internal and external audits.
- **Prompt decision and response/corrective action toward compliance offenses should be standard.** Compliance issues that have been identified should be subject to conduct inquiry, and corrective actions should be taken against responsible parties as identified within the health plan and CMS disciplinary guidelines.
- **The health plan should deploy fraud, waste and abuse programs** aimed at prevention, identification, investigation and resolution of risks related to potential fraud, waste and abuse including continuous monitoring capabilities aimed at early detection of incidents.

The eight areas above are common to any effective health plan government program compliance model.

Getting started: Key considerations for health plans implementing a health insurance exchange compliance program

The health insurance regulatory compliance environment is complex and evolving. There are a number of net new requirements and the likelihood of greater regulatory scrutiny is high. As a result, health plans should take a focused and systematic approach, when building a health insurance exchange regulatory program and infrastructure.

Therefore, health plans should consider the following:

- **Plans should implement a regulatory requirements framework that enables real time monitoring and rapid response.** Health plans should conduct a detailed review of the published federal and state regulations and document the regulatory compliance requirements. They should then take into account which requirements may still be "undefined" and anticipate potential changes and implications.
- **Risk assessment processes must be ongoing.** Health plans should assess current operations and related business processes and controls against the regulatory requirements framework and identify areas that present a gap. They should then identify and document the business risks associated with these gaps, as well as the uncertainty

around the regulatory environment moving forward. Early on, the number and types of risks will be high, and it will be important for health plans to effectively assess risks, costs, workarounds, and clear priorities for remediation and monitoring.

- **Implementation of a strategic and proactive compliance program and organization.** With the requirements, gaps, processes and risks defined and prioritized, health plans can then work toward defining and implementing the optimal compliance program. This will include detailed program requirements, processes, controls, and tools for monitoring and reporting on compliance risks on an ongoing basis.

Compliance with federal and state-level HIX requirements is now a reality for plans choosing to operate in the exchanges. In its memos and notices, CMS has outlined the areas it will monitor. These areas touch key parts of the health plan functioning in exchanges. Some of the areas are similar to what we encounter in Medicare and Medicaid health plans and some are unique to the exchanges. A starting point for development of an effective exchange compliance program may be a plan's Medicare or Medicaid compliance program. Plans will want to ensure that their compliance program includes the requirements outlined by the OIG and demonstrate that they are able to perform the appropriate compliance activities. These activities should include a strong process for auditing and monitoring; training programs; detecting and preventing fraud, waste, and abuse; and reporting of compliance issues to the plans leadership. Among the considerations that executives must weigh is to balance the focused attention that HIX compliance requires, while effectively aligning these compliance activities to the company's broader compliance program and infrastructure. Once that alignment is achieved, the operations of the business can be enhanced through strong and proactive compliance.

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