

Rhode Island State Flexibility to Stabilize the Market Grant, Cycle II: Project Narrative

A. Eligibility

The State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has broad authority under its enabling statute to (a) guard the solvency of health insurers; (b) protect the interests of consumers; (c) encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and (d) view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.¹ With this authority and through its statutes and any subsequent regulations², Rhode Island is currently enforcing Affordable Care Act (ACA) market reforms and consumer protections under Part A of title XXVII of the Public Health Service Act (PHSA) and is not receiving other Federal grant dollars for the same market reforms activities for which we are pursuing funding under the State Flexibility to Stabilize Market Grant Program, Cycle II (State Flexibility Cycle II).

B. Description of Current Market Reform Processes

OHIC has a comprehensive and innovative form and rate review process for the individual, small group, and large group insurance markets. OHIC was awarded four Rate Review Grants totaling \$8.5 million and successfully completed its deliverables on the Cycle I-IV grants, as reflected in our quarterly and final reports submitted to the federal government.

¹ OHIC Purposes Statue: <http://webserver.rilin.state.ri.us/Statutes/title42/42-14.5/42-14.5-2.HTM>

² Statutes that reference access, continuity, and quality of services and OHIC's authority over carriers and the ability to perform market conduct examinations: RIGL Section 27-13.1-4; 27-18.8, 29-18.9, 27-41; 27-18; 27-19; and 27-20

In October 2016, OHIC was awarded an Enforcement and Consumer Protections Grant (ECP) that enabled our office to make significant progress and advances in its efforts around compliance with non-discriminatory coverage, coverage for preventive health services, mandated appeals processes, and behavioral health parity. The ECP grant helped OHIC resume its Market Conduct Exam (MCE) on Mental Health Parity and the results will help OHIC make recommendations and potentially establish new requirements or regulations to better enforce parity. OHIC also strengthened its form review function using methods and information revealed through its ECP grant efforts, to analyze hundreds of plan designs each year to ensure that they meet federal and state requirements while protecting the consumer.

In 2018, OHIC was awarded State Flexibility to Stabilize Market Grant Program, Cycle I (State Flexibility Cycle I) funds. The State Flexibility Cycle I funds permitted OHIC to conduct a market scan of the four major carriers to ensure that plans that have been approved by OHIC for sale in the Small Group or Individual market meet all state and federal requirements. OHIC assessed and audited data from the four major carriers and utilized such data to determine adherence to the rules for discontinuing a plan already in force with an individual or an employer. OHIC also performed a comparison of the Rhode Island's current EHB Benchmark Plan with other state Benchmark Plans, as well as reviewing the benefit coverage would be beneficial both to those purchasing in Rhode Island and to inform other states considering EHB Benchmark Plan selection. In conducting its analysis, OHIC ensured that its EHB Benchmark Plan would continue to meet the needs of Rhode Island's Individual and Small Group markets to include all categories of required EHB coverage.

By addressing the reforms as described above, OHIC successfully improved the effectiveness of its annual regulatory review of coverage documents to assess consumers' needs and support the

development of innovative measures to ensure sustainable access to affordable health coverage in Rhode Island's Individual, Small, and Large Group markets.

We propose to use funds available through the State Flexibility Cycle II grant to address the following three market reform and consumer protection provisions under Part A of Title XXVII of the PHSA:

1. Section 2702: Guaranteed Availability of Coverage
2. Section 2703: Guaranteed Renewability of Coverage
3. Section 2707: Non-discrimination under Comprehensive Health Insurance Coverage (EHB Package)

OHIC will fulfill these State Flexibility Cycle II Grant objectives through the activities detailed in this application. We are proposing to create a consumer-centered website that **will enhance OHIC's ability to receive and respond to consumer questions, comments, and complaints to ensure access to and maintenance of health insurance coverage**; to enhance OHIC's utilization review data portal to better identify discriminatory practices; and to hire a staff person to improve access to behavioral health services and ensure behavioral health parity. The details of each of these three market reform activities will be described in further detail below.

Rhode Island's Form Review Process and Regulatory Structure

As of April 2020, there were approximately 200,293 covered lives in the fully-insured Rhode Island health insurance market. There are four major issuers in the commercial market, excluding those that cover only individuals over 65 years of age: Blue Cross Blue Shield of Rhode Island (BCBSRI), UnitedHealthcare (United), Tufts Health Plan (Tufts), and Neighborhood Health Plan

of Rhode Island (NHPRI). OHIC has jurisdiction over Rhode Island's fully-insured commercial health insurance market, which includes the individual market, small group market, and large group market. BCBSRI, United, NHP, and Tufts comprise 64%, 16%, 15%, and 5% of the fully-insured market share respectively. The individual and small group markets account for 23% and 25% of the fully-insured health insurance market respectively.

Form Review and Regulatory Structure

Under the four Rate Review Grants, OHIC not only strengthened and formalized its rate review and Affordability Standards work, but it also used funds to hire staff, build up, and internalize policies and procedures related to form review. This work includes:

- Institutionalizing the form and rate review process by developing a policies and procedures manual that outlines OHIC's regulatory authority to conduct form and rate review, the timeline and documents associated with filings, staff functions, and the review process;
- Hiring staff to conduct a thorough and comprehensive form review process, with a focus on collecting and analyzing complaints and benefit coverage issues from both a provider and consumer perspective. Under the rate review grants, staff started the process of expanding form review beyond document-level compliance; and
- Developing a formal process for MCEs, including incorporating the usage of data from Rhode Island's All Payer Claims Database (APCD)

More recently the ECP Grant helped OHIC further enhance its form review process by:

- Securing a consultant to help develop a form review checklist of Discriminatory Practices for Prescription Drugs;

- Designing a set of questions for issuers on preventive coverage, especially their compliance with no cost-share;
- Providing training for two new staff on the preparation, execution, and analysis of the Plan Management Tools suite.

Annual Form Review Process for the Individual and Small Group Market

The timeline for OHIC’s annual form review process is as follows:

December–March: Prepare and release form filing instructions. This includes soliciting feedback from interested parties—including the issuers and Rhode Island’s state-based marketplace (HealthSource RI (HSRI))—and revising the form filing instructions to reflect compliance with changes in state or federal statute or regulation, as well as coverage issues surfacing since issuance of previous instructions. Current form filing instructions are made available on SERFF.

April: Standard Form filings for Individual and Small Group plans are due. Preliminary review begins. Standard forms include: Certificates of Coverage, Group Policies, and Schedules of Benefit listing Essential Health Benefits (EHB), Rhode Island Benefit Mandates, Network Adequacy policies, Benefit determination policies and procedures, benefit crosswalks for terminated and modified plans, document Readability scores, benefit exclusions, and standard benefit provisions set forth in applicable federal and state health insurance regulations. These documents do not include benefit design cost shares.

May: Detailed form filings for Individual and Small Group plans are due and review is initiated. These documents contain specific consumer cost-sharing information and network design,

including the detailed Schedules of Benefits for Medical/Surgical, Dental, Vision, and Prescription Drugs.

June-August: Complete the review of form filings for compliance with state and federal requirements and decisions issued. OHIC staff review each form filing and all documents submitted for compliance according to Form Filing Instructions as well as state and federal rules.

A selection of compliance checks includes a review of the following:

- a. EHB annual or lifetime dollar limits, deductibles limitations, and other mandated cost share limitations;
- b. Coverage for preventive services without cost sharing;
- c. Cancellations and termination policies consistent with state and federal requirements;
- d. Ensuring that the plan provides coverage for parity in mental health and substance use disorder benefits;
- e. Requirement that issuers follow state and federal rules around the provision of habilitative and rehabilitative services;
- f. Coverage for all state benefit mandates and review for compliance with all standard insurance provisions found in state and/or federal statutes.;
- g. Requirement that processes to inform enrollees and providers of prescription drug formulary changes and exceptions;
- h. Ensuring policies and procedures demonstrate access to professional, facility, and other providers sufficient to provide coverage in a timely manner and for the benefits covered in the issuer's health insurance plans, whereby the issuer does not impose obstacles that unreasonably affect access to care; and

- i. A complaint and benefit determination appeal process that meets state and federal laws and regulations.

September: Complete the run of the Plan Management Tools inclusive of the Master Review, Data Integrity, Network Adequacy, and Formulary review tools. Once the run is completed, we review and analyze the results and identify items such as formulary outliers, needed changes to formulary templates for specific conditions/medications and business rules warnings that need clarification. OHIC then proceeds to communicate with specific carriers about the findings and awaits the carriers' explanations or changes.

All aspects of the form review process are coordinated with the rate review process that occurs in the same timeframe. Many decisions or clarifications on the form review side can affect premium development and OHIC staff work closely to ensure that the two processes are aligned and the issuers are receiving clear and consistent guidance. During this process, OHIC also solicits and incorporates the input of key stakeholders, including its Health Insurance Advisory Council, and the general public. All fully-insured form/rate filings are publicly disclosed and prominently posted on OHIC's [website](#) and are available through SERFF.

Current Capacity for Selected Market Reforms

Section 2702 – Guaranteed Availability of Coverage

OHIC has made significant progress in its annual assessment of health plans determining compliance with a number of federal and state requirements around guaranteed availability of coverage.

Each year, HSRI, Rhode Island's state-based marketplace, and OHIC meet regularly to collaborate on the rate and form review process in preparation for the Individual market's open enrollment period. HSRI's eighth open enrollment period took place November 1, 2020 – January 23, 2021. In 2021, HSRI offered 20 plan options from two major carriers. Small group and large group enrollment remains on a rolling anniversary basis. Both small and large group can be purchased direct or through brokers, and small group plans can also be purchased through the HSRI's Small Business Health Options Program (SHOP), known as HSRI for Employers.

Also of note, Rhode Island's current service area includes the entire state and is not broken up into smaller service areas given its size. Therefore, OHIC typically does not allow its carriers to limit the coverage in the individual or group market to any geographic subset of Rhode Island. There have been some tiered products attempted and previously approved by OHIC where only a single hospital system and its privileged providers were part of a tiered product. OHIC only allowed it to be sold to consumers living within a particular zip code even though broader coverage was afforded at a higher cost tier. Note that this product was not successfully sold in Rhode Island. OHIC has since not approved non-tiered products that do not have statewide coverage as it has been determined that these products have not met network adequacy and availability standards.

To further enhance guaranteed availability of coverage, Rhode Island has made significant strides in examining network adequacy as it relates to the availability of coverage. OHIC currently requires that any plan sold in Rhode Island must provide access to a sufficient number of providers—professional and facility—in all specialty and health care service categories to meet all stated benefit coverage defined in its beneficiary agreements without unreasonable delay. OHIC's examination also includes use of Plan Management tools to assess adequacy of

Essential Community Providers and will be using newly promulgated regulations to R.I.G.L. §27-18.8 consistent with the NAIC Network Adequacy Model Act. OHIC is currently conducting a MCE of the Network Adequacy of Rhode Island's four major carriers that is expected to be completed by mid-late 2021.

OHIC utilized funds from the State Flexibility Cycle I Grant to expand upon functionality of an existing data portal (herein: OHIC Portal.) The enhancements made to the existing OHIC Portal has allowed for a more in-depth review of benefit determination practices among carriers in the state. The revisions will provide OHIC with the capability to compare year-over-year data by carrier that will provide insight into any trends that may require further investigation or MCE.

Additionally, utilizing the funds from the State Flexibility Cycle I Grant, OHIC issued a Request for Information (RFI) to the major carriers in Rhode Island, OHIC, which requested quantitative data on the number of individuals enrolling in each Plan Year through special enrollment periods, and the number of individuals dropping coverage during each Plan Year. Comparing the data gathered across issuers provided OHIC with preliminary indicators of whether individuals in the Rhode Island market are (1) more likely to enroll with one carrier over others during a qualifying event, and/or (2) more likely to drop coverage from a given carrier. When analyzed in the context of the carriers' market share, the former may indicate easier access to enrollment or more comprehensive coverage for those with changing health needs. The latter, conversely, may indicate that the coverage provided in practice did not meet the needs or expectations of enrollees. Both may lead to risk selection based on discriminatory factors, such as chronic medical need, age, income, etc. OHIC will continue to utilize this information to inform its annual form and rate review process to ensure that carriers continue to adhere to the requirements of Market Reform Section 2702 – Guaranteed Availability of Coverage.

Section 2703 – Guaranteed Renewability of Coverage

Along with OHIC’s form and rate review examinations of small group and individual market documents for approval for use both on and off its state exchange, it poses questions to each carrier when it discontinues or modifies a plan. Each carrier is required to document for review a listing of each discontinued or modified plan, the number of enrollees in each plan, the broad reason for such changes, and a crosswalk to coverage for the discontinued plan. The carriers also note what plans are new and existing. This allows OHIC to assess that beneficiaries are not left without coverage and that the beneficiaries are placed in a similar plan. OHIC also prescribes the required health plan renewal and discontinuance notification letters sent to the consumers each year explaining changes to their existing plan or mapping them to a new, but similar, plan. The notices also present the consumer with a detailed breakdown of the drivers of their premium, including the contribution of medical trend, changes in benefit/cost sharing, administrative costs, and taxes and fees.

Data collected under the Guaranteed Renewability RFI further assisted in OHIC’s analysis of Guaranteed Availability compliance. The Guaranteed Renewability RFI requested that issuers describe changes in benefits for modified health plans as well as the differences in coverage for plans that replaced discontinued plan options. When compared to previous Centers for Medicare & Medicaid Services (CMS) guidance on potential discriminatory benefit designs, the responses provided to OHIC did not indicate that plan modifications or discontinuances were discriminatory or otherwise intended to discourage continued enrollment from higher risk groups. OHIC utilized the findings of this RFI to update its “Plan Crosswalk” which is used in its annual form and rate review. Moving forward, OHIC will continue to modify its review documentation to ensure that its annual form and rate review processes are sufficient in

determining compliance with Market Reform Section 2703 – Guaranteed Renewability of Coverage.

Section 2707 – Non-discrimination under Comprehensive Health Insurance Coverage (EHB Package)

In conformance with Section 2707 of the PHSA, Rhode Island has required and has assessed carriers for coverage for EHBs as defined under Section 1302(a) of the Patient Protection and Affordable Care Act. It also monitors on an annual basis the cost-sharing requirements not exceeding those limitations imposed as provided for under paragraphs (1) and (2) of section 1302(c) and those age limitations set for child only dental and vision plans. Since January 2014, Rhode Island has selected its Benchmark plans to include a Rhode Island BCBS plan, a METLIFE Dental, and an FEP vision plan. These plans meet all essential benchmark plan rules, state mandates, and standard provisions. Each year, Rhode Island updates the maximum out-of-pocket and cost sharing rules as well as any rate rule changes making the necessary assessment adjustments in approval plans for use both on and off the exchange for both the individual and small group markets.

Prior to using the Plan Management tools for assessing coverage meeting RI's benchmark plans each year, OHIC staff uses its own instructions, benefit template, cost share crosswalk, and internal reviewer tools to determine compliance with all benchmark coverage for each plan. As noted above, it is a two-phase process allowing for a very extensive evaluation of carrier compliance. OHIC recognizes the level of state mandate coverage in Rhode Island with approximately 69 mandates. It also recognizes that there is a need to evaluate where EHB coverage stands in Rhode Island compared to other states and what, if any, potential exists to

modify its benchmark plan while not compromising key coverage, affordability, and compliance with state and federal mandates.

OHIC utilized State Flexibility Cycle I Grant funds to perform an assessment of Rhode Island's EHB Benchmark Plan. This assessment was conducted via a comparison of five peer states, (CT, DE, MA, NH, VT) which successfully provided OHIC with a comprehensive understanding of the EHB Benchmark Plan selection process, and the information necessary to make an informed EHB Benchmark Plan selection that is in the best interest of Rhode Island consumers. The outcome of the analysis showed that Rhode Island's current EHB Benchmark Plan generally provides a comparable or more comprehensive benefits package than the peer states included in the analysis. The only benefits covered by peer states that are not covered in Rhode Island's EHB Benchmark Plan are temporomandibular joint syndrome (TMJ) treatment and weight loss programs. Additionally, Rhode Island is the only state included in this analysis that does not apply treatment limitations for outpatient rehabilitation service, rehabilitative occupational therapy, rehabilitative physical therapy, skilled nursing facilities, habilitation services, and hearing aids. Based on this review, OHIC informed CMS/CCIIO of its intent to retain the existing EHB Benchmark Plan.

The assessment of Rhode Island's EHB Benchmark Plan revealed a potential misunderstanding in the Rhode Island Benchmark Plan documents on the CMS and OHIC websites involving Methadone treatment coverage. Once the concern regarding the potential appearance of non-compliance was identified, OHIC collaborated with CMS to confirm OHIC's continued compliance with federal parity obligations.

The assessment also highlighted the need to ensure that there are systems in place to assess, on an on-going basis, how Rhode Island compares to its peer states and stay informed on current industry standards. This is a lesson that OHIC continues to employ after the completion of the State Flexibility Cycle I Grant to ensure carrier compliance with Market Reform – Section 2707 Comprehensive Health Insurance Coverage (EHB Package).

C. Proposed Activities for Planning and/or Implementing Market Reforms and Consumer Protections

Section 2702 – Guaranteed Availability of Coverage

Section 2703 – Guaranteed Renewability of Coverage

Improving health insurance coverage access and retention

The Guaranteed Availability and Renewability of Coverage provisions under Sections 2702 and 2703 ensure that products approved for sale in both individual and group markets are made available and renewable to any individual or employer that applies for coverage in the respective market.³ To ensure that issuers are meeting these requirements, OHIC is proposing to use Section 2702 and 2703 funds to improve our Office’s ability to receive and respond to website comments, questions, and complaints from consumers. Facilitating and empowering consumers to communicate with our Office will help improve our oversight over issuers’ maintenance of coverage options, enhancing both health insurance enrollment and retention. A robust consumer-friendly comment, complaint, and question interface will assist our Office in determining whether approved products are being appropriately offered for purchase and if any additional

³ The Guaranteed Availability and Renewability of Coverage provisions ensure any non-grandfathered product that is approved for sale in the individual, small group, and large group markets is made available for purchase to any individual or employer that applies for coverage in the respective market, unless an exception applies. The Guaranteed Renewability of Coverage provision ensures that issuers renew or continue coverage at the option of the individual or plan sponsor, unless an exception applies.

measures are needed from OHIC to strengthen coverage options provided by health insurance issuers.

To carry out this work, OHIC seeks to hire a website consultant through the State of Rhode Island procurement process who will work closely with Rhode Island Department of Information Technology (DoIT). DoIT's Project Review Board will help write the project requirements and also provide expertise and project coordination to align state efforts with the selected vendor. This project will involve a development and implementation phase, usability testing, and ensuring that existing staff can readily maintain the site for post-grant sustainability.

Section 2707 – Non-Discrimination under Comprehensive Health Insurance Coverage (EHB Package)

As discussed in Section B, OHIC currently examines compliance with non-discrimination provisions but is proposing two activities under the grant opportunity to 1) improve its utilization data analytic capability; and 2) hire additional staff and consultant expert assistance to enhance its focus on behavioral health access and parity.

1. Enhanced utilization review data portal

OHIC proposes to enhance its data portal for reporting of utilization review claims, denials, modifications, appeals, and complaints by specified medical and behavioral health service categories. This enhancement will be used to analyze data submitted by insurers and Benefit Determination Review Agencies to streamline the submission of required payer quarterly reports.

The improved data portal will provide OHIC with additional tools to analyze behavioral health parity and discriminatory practices to utilize in determining the need for MCEs. The improved

data tools will enable OHIC staff to quickly identify various trends in the healthcare marketplace, and to address any potential areas of entity non-compliance with state and federal requirements. These tools will help staff to work with entities to eliminate any potential barriers to consumer care based upon the quantitative information submitted.

2. Legal and Regulatory Support to Improve Access to Behavioral Health Services

Due to the need for highly specialized expertise, OHIC proposes adding a full-time legal and regulatory support position titled, “Senior Legal and Regulatory Analyst.” The Senior Legal and Regulatory Analyst will have direct oversight over OHIC’s State Flexibility Grant Cycle II, including the following three market reform activities: Guaranteed Availability, Guaranteed Renewability, and Non-discrimination under Comprehensive Health Insurance Coverage (EHB Package). In addition to overall project management of the Grant, The Analyst will focus on improving overall access to behavioral health services. The goals for the Senior Legal and Regulatory Analyst include:

- A. Oversight of all market reform activities and directing the project management in meeting all the deliverables of the State Flexibility Grant Cycle II, including vendor communications, oversight, and efforts to ensure that project deadlines are being met;
- B. Identify, prioritize, and recommend strategies for legal and regulatory support work to enhance OHIC's enforcement of health insurers' behavioral health coverage obligations; and
- C. Improve access to behavioral health services by addressing health insurance barriers to care.

This proposed activity includes the hiring of an expert legal consultant(s) to assist the Senior Legal and Regulatory Analyst in the following projects:

1. Oversight review to ensure health insurers' compliance with the current and past MCE recommendations;
2. Review recent litigation and administrative actions against insurers to identify new enforcement actions or MCEs to support non-discrimination under Comprehensive Health Insurance Coverage; and
3. Research and evaluate legislative, regulatory, and enforcement actions in other states that address behavioral health parity and effective coverage of behavioral health services, and advise OHIC on potential changes to current Rhode Island legislation and regulations.

D. Evaluation Plan

OHIC attests that it will comply with the reporting requirements outlined in the grant-funding announcement and that it will transmit the required data on a quarterly and annual basis throughout the life of the grant to ensure that milestones are being met and the goal and outcomes of the program are being achieved. OHIC will also comply with any data submission requirements that are revised in the future to reflect changes in regulations or guidance. OHIC's evaluation plan will monitor progress, with measurable outcomes, under the three market reform activities. This plan will ensure that deliverables are achieved on time and on budget and that sufficient structure, work plans, processes, and reporting tools are present to identify and mitigate issues as needed.

Key Indicators to be Measured

The Work Plan identifies the principal tasks and milestones to be completed and achieved within each area and each quarter of the funding period. These tasks and milestones are the project’s key indicators to be measured. We will monitor progress toward task completion and achievement of milestones on an ongoing basis. Other key indicators may be developed as the grant period progresses.

Baseline Data for Each Indicator

The template below presents the framework to be used in documenting applicable baseline data for each key project task and milestone. This data will provide the starting point from which project progress for each milestone will be measured, through the reports discussed below. This baseline data will be compiled at the initiation of the grant period and each project, as applicable.

Indicator	Project Lead	Baseline

Methods to Monitor Progress and Evaluate the Achievement of Program Goals

Project task and milestone progress will be monitored by the Project Manager and in quarterly reporting to HHS. OHIC will solicit input from the parties responsible for specific tasks and milestones. The evaluation process will include the following four elements:

1. **Project Status Reports:** Project status reports will focus in greater detail on which key tasks and milestones have been completed on schedule, those running behind schedule, and the mitigation strategy for those likely to miss the original scheduled completion date. For each key task and milestone likely to be late, a mitigation strategy will be identified, defining specific actions to be taken to assure completion in a timeframe that does not compromise

other tasks and milestones. The project leads will be responsible for overseeing task completion and mitigation strategy implementation for their respective projects.

2. **Deliverables Review:** A detailed deliverables review process has been implemented in order to assure the timeliness, accuracy, and completeness of project deliverables. Deliverable items will be reconciled with the Budget and Work Plan on an ongoing basis. The project team is committed to producing and receiving high-quality deliverables from both internal and external sources. We will continue to follow this approach, while focusing on quality improvement, taking into account the premium placed on the time and resources of project staff, as well as that of other stakeholders and consultants. The deliverables' content, schedule, presentation, tracking, and approval process will be agreed to in advance, with project staff, stakeholders, and consultants agreeing on the specific content, format, and criteria for all deliverables.
3. **Communication between Project Staff and Stakeholders:** An effective communications plan, to support both internal and external communications, is a key component of the project team's method to ensure effective progress monitoring and achievement of program goals. For external communications, we have established a structured stakeholder effort through our Health Insurance Advisory Council. For internal communications among project staff, tasks are managed through meetings and informal communications.
4. **Timely Interventions When Targets are Not Met or Unexpected Obstacles Delay Plans:** The Project Director will lead the effort in monitoring tasks, milestones, and overall goal progress. The principal tools for monitoring project performance will be the progress reports noted above, coupled with frequent communication between project staff, stakeholders, and consultants. The most effective risk management strategy is risk avoidance. Consequently,

our management team asks the following key questions of all parties responsible for project activities and tasks on an ongoing basis:

- a. Is the task scope being managed and assigned effectively?
- b. Are we meeting our schedule?
- c. Are deliverables completed consistent with quality standards?
- d. Are risks and issues managed appropriately?
- e. Is the project meeting all contractual requirements?
- f. Are stakeholders, including HHS, satisfied?

This ongoing communication enables us to identify the need for interventions in a timely manner or unexpected circumstances that may cause delay in task completion or milestone achievement. We will track issues and monitor, on an ongoing basis, the issues opened, closed, and pending each month and their relative priority and severity. The template below provides a Sample Issues Management List as an example of the type of tracking sheet we will use to monitor issues, as well as the status of key tasks and milestones—both completed and outstanding.

Project	Task	Due Date	Revised	Problem	Mitigation	Status
Lead	Milestone/ Deliverable		Due Date			

E. Commitment to Mentor States

OHIC agrees to mentor states that are in the process of planning and/or the implementation of market reform activities and best practices. OHIC will take every opportunity to share

assessment tools and templates with other states either directly or through its NAIC and federal agency contacts.