Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Exchange Issuer Best Practices 2018: Developing Comprehensive Health Insurance Issuer Casework Resolutions

Introduction

The Health Insurance Casework System (HICS) is the official tracking system for Exchange casework and is used by issuers that participate in the Federally-facilitated Exchange (FFE), including the State Partnership Exchange (SPE) and State-based Exchange using the Federal platform (SBE-FP), hereafter referred to as "Exchange." The Exchange uses HICS to route cases that require investigation and resolution to issuers. These cases are referred to as Category 2 – Plan and Issuer Concerns. Category 2 cases are the primary responsibility of issuers to research and resolve. However, Centers for Medicare & Medicaid Services (CMS) staff are available to provide technical assistance when needed. State regulators who request and secure access can view HICS cases.

HICS is also used to direct issuers to make changes to enrollment effective and end dates, changes to advance payments of premium tax credits (APTCs) and cost-sharing reductions (CSRs) resulting from appeal decisions, and other corrections, when it is not possible to make the changes via 834 transactions or supplemental enrollment files. These changes include, but are not limited to, the effectuation of some eligibility appeal decisions, retro-active insurance terminations for deceased consumers, CMS caseworker decisions, and when system technical enrollment blockers stop the generation of an issuer enrollment file.

CMS appreciates the steps the issuer community has taken since the launch of the Exchanges to promptly address casework matters and to propose HICS enhancements to support excellent customer service.

HICS Access and Casework Expectations

CMS expects qualified health plan (QHP) and stand-alone dental plan (SADP) issuers to thoroughly investigate and resolve consumer issues received directly from members or forwarded to issuers by states.

Additionally, issuers operating in the Exchange must investigate and resolve consumer cases, including complaints, forwarded by CMS via HICS in accordance with the requirements at 45 CFR 156.1010. Issuers should check HICS daily and monitor adherence to required resolution timeframes. To avoid delays, issuer staff should have appropriate access to enrollment files without the need for escalation to other internal issuer departments. If a case narrative is unclear, the issuer is expected to contact the consumer for additional information prior to referring the case back to CMS.

Issuers are expected to acquire and maintain sufficient access to HICS for their staff and train them to use the system. Having sufficient staff access to HICS will aid with consumer responsiveness, potentially avoiding the generation of additional and unnecessary HICS cases. Because HICS contains personally identifiable information and personal health information, issuer compliance with all applicable CMS privacy and security certification and training is required.

HICS is accessible to approved users via the following link: https://hics.cms.gov. Users are required to comply with all applicable laws and regulations associated with the use of this U.S. Government computer system. After logging on to the system, users can access the "Issuer User Manual" by selecting "Documentation" on the Casework Tracking Start Page menu. Issuers can request HICS access for users by completing HHS Form-745 Issuer HICS Access Form on CMSzONE. For additional questions about HICS access, issuers can contact the HICS Access Resource Mailbox at HICS_Access@cms.hhs.gov. HICS users must comply with the annual recertification requirement when notified and complete annual Computer Based Training.

When reviewing HICS cases, issuers should distinguish between directive cases that require them to act and non-directive consumer requests that require review prior to action and/or resolution. For example, an appeal decision sent via HICS from "Case Source: CMS Appeals Contractor" will include a case narrative and changes that the issuer should effectuate as directed. The issuer must update the Exchange through the case resolution process. In contrast, a case narrative such as "Consumer believes that she was terminated in error and desires reinstatement," is a non-directive narrative that requires the issuer to investigate first. The issuer should take action to update the consumer's record in accordance with applicable laws and policies and only if supported by evidence the consumer provides or the issuer develops. In all cases, the issuer must contact the consumer with the resolution of the HICS case.

Infrequently, a HICS case narrative may include directive instructions from CMS that the issuer believes to be inconsistent with law or policy. In this situation, the issuer should work with CMS to resolve the matter, starting with the assigned CMS caseworker. Issuers should not effectuate requests inconsistent with CMS policy and guidance.

In general, issuers are not able to reassign HICS cases. With a recent implementation of the HICS Direct Disputes functionality, specific cases may now be routed directly to the Enrollment Resolution and Reconciliation (ER&R) contractor to work. These cases include enrollment blockers (new error code "enrollment blocker"), changes to APTCs, changes to total premium amount that cannot be resolved through automated reconciliation and term no longer eligible (NLE) appeals. Any cases pending with the ER&R contractor will not count toward the three (3) or fifteen (15) day resolution timeline until they are returned to the issuer and the clock restarts. The time it will take to resolve a HICS Direct Dispute will be similar to disputes submitted via a dispute form.

Issuers must continue to review and resolve consumer issues after leaving a service area. Issuers entirely exiting Exchange operations should contact their Account Manager about continued casework expectations.

HICS General Reminders and Best Practices

Category 2 HICS cases reflect issues that inherently require issuer attention. These issues include, but are not limited to, the following subcategories:

- Issuer Enrollment/Disenrollment
- Claims Processing, Denials, Benefit Appeals
- Quality of Care/Provider Fraud Allegations
- Coordination of Benefits
- Premium Payment
- Cost-Sharing
- Rate Review
- Issuer Customer Service
- Marketing Complaints

- Agent/Broker-Initiated Compensation Issues
- Access to Services/Benefits
- Special Enrollment Period (Issuer Action Required)
- Reinstatement/Re-enrollment Request
- Cancellation/Termination Request
- Consumer Believes APTC not Awarded Properly
- Auto Re-Enrollment or Renewal
- Eligibility Appeals Related (OHI Use Only)
- Alternative Format Request Issue
- Other

CMS expects issuers to always annotate cases with comprehensive notes. As a best practice, issuers should immediately annotate actions taken in HICS. Notes at each stage should include the following:

- Initial Issuer Notes:
  - Acknowledge receipt
  - Brief issue description, including clarifying details not present in the CMS case narrative
  - Find related cases and prevent duplicative work by utilizing the "Find Repeat Case" feature, record related cases found
- Interim Issuer Notes:
  - Clearly and concisely summarize each step taken, especially if approaching deadline. Include: actions taken; internal referrals; and/or contact with CMS staff.
  - Contact Information:
    - Who: Identity verified, names and relationships/titles
    - When: Dates and times
    - How: Method of contact (Including phone numbers and email addresses)
    - What: Summary of the information received and conveyed
- Resolution Issuer Notes and Documentation:
  - Resolution notes should be more extensive than brief one-liners like: Contact Made, Issue Resolved, and Unable to Contact
  - Pertinent case facts, for example:
    - Issuer records updated and/or external referrals to Enrollment Resolution and Reconciliation (ER&R) or the Exchange Operations and Support Center (XOSC) helpdesk
    - Enrollment or termination information received electronically from CMS
    - Payment and billing history
  - How and when complainant was notified of outcome (verbal and written or written only)
  - Uploaded copies of correspondence sent to consumers and other entities

If the issuer requires assistance, the issuer should contact their CMS caseworker prior to resolving the case. Issuers may choose to establish a critical inquiry unit to resolve difficult cases. In some situations, HICS case notes may be released to requestors under the Freedom of Information Act (FOIA). Therefore, case notes' content and comments should be clear, neutral, and factual.

Examples of Category 2 Cases and Best Practice Resolution Notes

Category 2 HICS resolution entries need to be comprehensive and reflect established CMS policy. Below are examples of best practices for resolving Category 2 cases and appropriate issuer resolution notes.

1. Reinstatement Requests (excluding non-payment terminations)

Reinstatement cases may be cases where the consumer believes he or she had insurance inappropriately terminated, such as through an issuer reconciliation error or an Exchange processing error.

- Per CMS, [Name] erroneously had coverage terminated by Exchange, only daughter's [Name] insurance was to be terminated. Consumer's coverage was reinstated effective [Date], reinstatement was submitted to the ER&R contractor on [Date]. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Advised consumer will owe [$$$] in premiums, how to pay, and to pay this amount by [Date] to stay enrolled. Informed consumer that Exchange records will take 1-2 reconciliation cycles to update. Consumer was satisfied and had no other issues to report. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] believes that his coverage was inappropriately terminated. Issuer confirmed that the consumer is currently a member and that contact information in the HICS case and on file is a match. Consumer is enrolled in [Specific Plan] with effective date of [Date] and has not had coverage terminated. Reviewed enrollment files and records. Enrollment 834 file received on [Date], binder was paid on [Date] and enrollment was effectuated on [Date]. A resolution letter was uploaded into HICS and will be mailed to the consumer on [Date].

- [Name] requested reinstatement of insurance. Issuer is unable to honor consumer's request to change the effective date per CMS and/or issuer policy. Issuer reviewed enrollment files and records, which show a termination date of [Date] from 834 transmitted on [Date]. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Issuer learned that consumer failed to clear a Citizenship/Immigration data matching issue. Consumer was informed how to attempt to resolve the data matching issue and that Exchange may grant retroactivity. Consumer was informed of appeal rights and how to file. Issuer discussed options for continued insurance off-Exchange. Consumer appreciated the information. Resolution letter was mailed on [Date] and uploaded into HICS.

2. Payment Disputes and Non-Payment Reinstatement Requests

In payment dispute cases, consumers allege insurance was terminated or not effectuated despite making necessary monthly or binder payments. Issuers should provide detailed payment information in case resolution notes and should avoid resolution notes that only assert, "Termination for non-payment is correct." This will prevent unnecessary issuer inquiries during any appeal process. Payment information should include: billing notice dates and balances; payment due dates; APTCs eligibility; grace period start and end dates; payment methods, amounts and receipt dates; customer service summaries and dates; termination dates; documentation of billing system errors; and billing/payment corrections.

- [Name] contacted the Exchange after termination. Consumer alleges all payments were made on time. Issuer reviewed enrollment and payment records. Consumer is APTCs eligible and was sent initial bill on [Date] for [$$$] due on [Date] and subsequent bills on … Grace period began [Date] and ended on [Date]. Consumer's coverage was terminated on [Date] for non-payment. Upon review, it appears consumer's payment received on [Date] of [$$$] by check and subsequent payments … were not appropriately applied within the applicable grace period. Issuer has now corrected their payment records and submitted a reinstatement correction to the ER&R contractor on [Date]. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer understood and has been advised that Exchange records will be

updated within 1-2 reconciliation cycles. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] contacted the Exchange after termination. Consumer alleges all payments were made on time. Issuer reviewed enrollment and payment records. Consumer is APTCs eligible and was sent initial bill on [Date] for [$$$] due on [Date] and subsequent bills on … Grace period began [Date] and ended on [Date]. Consumer's coverage was terminated on [Date] for non-payment. Upon review, consumer made no payments and had coverage terminated correctly. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer understood and was provided with information on enrollment periods. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] contacted the Exchange after receiving notice that the binder payment was not received. Consumer believes all payments are being paid via auto-pay. Issuer reviewed enrollment and payment records. Consumer is not APTCs eligible and was sent initial bill on [Date] for [$$$] due on [Date]. Upon review, consumer made no payments. Issuer contacted consumer on [Date & Time] at [Phone Number]. Identity verified. Issuer discovered that auto-pay was active with previous issuer in prior year and consumer was cross-walked to new issuer. Consumer was advised how to pay binder payment and how to activate auto-pay. Consumer was satisfied with issuer explanation. Resolution letter was sent on [Date] and uploaded into HICS.

3. Premium Disagreements

In premium disagreement cases, consumers dispute or are confused by the amount of their monthly premium payments. Examples include: cases involving loss of APTCs due to an expired income data matching issue and cases where APTCs are applied incorrectly.

- [Name] opened a HICS case via the Exchange after resolving an income data matching issue and complains that his APTCs were only restored prospectively. Issuer cannot reinstate APTCs retroactively. Issuer called [Phone Number] on [Date & Time] and spoke with the consumer. After verifying identity, the consumer was advised how to file an APTCs appeal with the Exchange for the retroactive period. A resolution letter was sent on [Date] and has been uploaded into HICS.

- CMS Regional Office opened a HICS case for [Name] who alleges monthly premium amount billed is incorrect. A review of Exchange files shows consumer's premium, net APTCs, is [$$$] for [Date] onward. However, issuer did not apply APTCs correctly and consumer was billed the total monthly premium of [$$$]. Consumer paid billed amount on [Date]. Application of APTCs has now been corrected and consumer's record matches the Exchange. Consumer's next premium payment of [$$$] is due on [Date], after applying overbilled and overpaid premium amount to the consumer's account. Consumer could not be reached after three attempts at [Phone Number] on [Date & Time], [Date & Time] and [Date & Time]. A resolution letter was sent to the consumer on [Date] and uploaded into HICS.

- [Name] contacted the Exchange on [Date] and complained that her January 2018 premium bill was incorrect. Exchange and issuer records show consumer was billed correctly for her 2017 policy with a member responsibility of [$$$]. The most current file received from the Exchange on [Date] is for insurance effective 1/1/18. The total monthly premium is [$$$], the monthly APTCs are [$$$] leaving a monthly 2018 responsibility of [$$$]. Consumer has not yet made January payment. The invoice sent reflected her 2017 monthly bill and was incorrect after her 2018 enrollment. Issuer's system

shows a correct balance of [$$$] through 1/31/18. Consumer will see correction on the next bill. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer was angry about incorrect bill, understood correct amount due and had no other issues to report. A resolution letter was sent on [Date] and has been uploaded into HICS.

4. Effective Date Changes

Reasons for effective date changes can be related to special enrollment periods (SEPs), Exchange or issuer errors, or terminations.

- Exchange instructed issuer to change effective date for [Name] from August 1, 2018 to July 1, 2018 due to correction of loss of minimal essential coverage date. Issuer reviewed enrollment record. Enrollment 834 file received on [Date]. Enrollment was previously effectuated on [Date] for August 1 effective date. Issuer changed effective date to July 1, 2018 in accordance with Exchange instructions and will update Exchange records through reconciliation. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Issuer advised consumer of new effective date and additional [$$$] in premiums owed. Consumer was satisfied and had no other issues to report. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] requested change in effective date of insurance due to need to utilize medical services. Issuer is unable to honor consumer's request to change effective date because there is no basis for change in CMS and issuer policy. Issuer reviewed enrollment record, which shows effective date of [Date]. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer was informed issuer cannot honor request. Consumer was not satisfied with resolution. Resolution letter was sent on [Date] and uploaded into HICS.

5. Retroactive Terminations

Retroactive terminations may be initiated at the consumer's request due to errors by the Exchange or others. CMS may also directly review retroactive termination HICS cases and may generate complex casework requests or directions to issuers.

- [Name] contacted the Exchange on 7/6 to request a 6/30 termination effective date. Issuer reviewed enrollment and customer service records. Issuer received a termination date of 7/20 from the Exchange. Issuer will allow for a prospective termination date that is up to 14 days prior to the Exchange termination date, per the issuer's termination policy and 45 CFR 155.430 (d)(2)(iii). Issuer will submit new termination date of 7/6 via automated reconciliation by [Date] and updated to Exchange records within 1-2 reconciliation cycles. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution and the [$$$] premium refund. Identity verified. Consumer understood and has been advised that requests for retroactive termination dates generally are not reviewed by CMS through its appeals process. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] seeks a termination date of [Date] and the issuer shows [Date]. Issuer reviewed enrollment and customer service records. Issuer is not able to provide an earlier termination date per CMS/issuer enrollment policy. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer has been advised that requests for retroactive termination dates generally are not reviewed by CMS through its appeals process. Resolution letter was sent on [Date] and uploaded into HICS.

- Issuer received directive from CMS to adjust the termination date for family [Name 1], [Name 2] and [Name 3] from [Date] to [Date] due to an Exchange error. The termination date has been changed. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Resolution letter was sent on [Date] and uploaded into HICS.

6. Auto-reenrollment Cancelations

Due to batch auto-reenrollments (BAR) and the potential for consumers to generate multiple applications or other files during the open enrollment period, HICS cases may be generated to resolve enrollment errors. Consumer choices to cancel BAR are to be honored by issuers and reported to the Exchange through reconciliation as appropriate.

- [Name] contacted the Exchange on 12/22/17 to indicate that their 2017 plan auto-debited premiums for January 2018 even though they had enrolled with another issuer for 2018. Issuer reviewed enrollment, customer service and payment records. Confirmed consumer is a member and that contact information in the HICS case and on file is a match. Passive enrollment file received on 10/29/17 and submitted on 10/31/17. Issuer canceled the enrollment effective 12/31/17 in issuer systems. Because issuer auto-debited consumer for January, consumer is due a refund of [$$$]. Issuer issued check dated [Date] for that amount. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name] was auto-reenrolled into a 2018 plan with [Issuer A] from a 2017 [Issuer B] plan, because [Issuer B] will not be participating in the Exchange in 2018. Consumer indicated they do not want 2018 insurance with our company. Since no binder payment was made, insurance was not effectuated. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Consumer was advised to disregard our plan materials and invoice. Our company will send a transaction to the Exchange to inform CMS of consumer's choice. Resolution letter was sent on [Date] and uploaded into HICS.

7. Appeals

Generally, appeals decisions are communicated through 834 transactions, and HICS cases will only be required to convey a mid-month effective date, for example for a newborn, or to convey instructions for implementing eligibility pending an appeal decision.

- Issuer received a HICS case for [Name] who has a pending appeal of ineligibility for APTCs. Consumer wants to receive APTCs during the appeal. Issuer is extending APTCs retroactive to [Date] in accordance with CMS instructions. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution and new premium amount. Identity verified. Resolution letter was sent on [Date] and uploaded into HICS.

8. Exchange Enrollment Corrections

Certain corrections to consumer's account require the consumer to visit the Exchange to resolve. These include date of birth corrections and primary residence address changes. An electronic notification is sent to the issuer to effectuate the correction. Preferably consumer's should report mailing address changes to the Exchange, however issuers can accept mailing address changes and update Exchange records

through reconciliation. In repeat or complex cases where an electronic notification is not sent (for example, if an enrollment blocker is in place), issuer may contact their CMS caseworker for assistance.

- [Name]'s request to change primary residence address was received via HICS. Primary residence address on the enrollment file cannot be corrected by the issuer as no CMS data files were received. Issuer contacted consumer on [Date & Time] at [Phone Number]. Identity verified. Consumer was instructed to contact the Exchange directly by calling 800-318-2596 or to have an authorized representative do so. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name]'s request to change mailing address was received via HICS. Residence address, as received in CMS data file on [Date], is not changing. Mailing address was updated in issuer records and will be updated to Exchange through reconciliation. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Issuer advised consumer that the mailing address has been updated, but in the future consumer should instead contact the Exchange. Resolution letter was sent on [Date] and uploaded into HICS.

- [Name]'s request to correct date of birth was received via HICS. Date of birth on the enrollment file cannot be corrected by the issuer as no CMS data files were received. Issuer contacted consumer on [Date & Time] at [Phone Number]. Identity verified. Consumer was instructed to contact the Exchange directly by calling 800-318-2596. Resolution letter was sent on [Date] and uploaded into HICS.

9. Special Enrollment Period Verification (SEPV)

New applicants (those not already enrolled in Exchange insurance) who attest to certain types of special enrollment period (SEP) qualifying events are subject to pre-enrollment verification. These consumers must submit documents that confirm their SEP eligibility, choose a plan and pay their premium. Once their SEP eligibility is verified and consumers make a plan selection and pay their premium, consumers are enrolled and can start using their insurance. The effective date of coverage, based on their SEP type and date of plan selection, can be retroactive. At this time, SEPV applies to SEPs for loss of minimum essential coverage, move, marriage, adoption, foster care placement, qualifying court orders and denial of Medicaid/CHIP.

- Case received from Exchange because [Name] did not receive a member ID card after enrolling. Issuer reviewed enrollment record and discovered that the consumer did not submit documents for SEPV. Thirty days have not yet elapsed from plan selection. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution and informed consumer about the SEPV process. Identity verified. Resolution letter was sent on [Date] and uploaded into HICS.

- Case received from Exchange because [Name] did not receive a member ID card after enrolling. Issuer reviewed enrollment record and discovered that the consumer did not submit documents for SEPV. Thirty days have elapsed from plan selection on [Date], however consumer is still within sixty days of the qualifying SEP event. Issuer contacted consumer on [Date & Time] at [Phone Number] regarding resolution. Identity verified. Issuer advised consumer to return to their Exchange application, attest to SEP qualifying event again, choose same or different plan, and submit verification documents. Resolution letter was sent on [Date] and uploaded into HICS.

10. Issuer Communication with Consumers

Regular and complete communication with consumers can prevent unnecessary repeat HICS cases and reduce case volume. For example, informing consumers how long it will take records to update or binder payments to process.

- [Name] contacted the Exchange to verify their reinstatement immediately after issuer action. Exchange records did not reflect reinstatement. Issuer reviewed enrollment record and verified that the case was properly referred to the ER&R contractor on [Date]. Issuer contacted consumer on [Date & Time] at [Phone Number]. Identity verified. Issuer explained that consumer was reinstated effective [Date], but reinstatement takes 1-2 reconciliation cycles to update to Exchange. Consumer satisfied with explanation. Resolution letter was sent on [Date] and uploaded into HICS.