

Issuer Best Practices 2020: Developing Comprehensive Health Insurance Issuer Casework Resolutions

Samuel J. Howard

*Center for Consumer Information &
Insurance Oversight (CCIIO)*

February 10, 2020

<https://www.regtap.info/FFENR.php>

The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This material summarizes current policy and operations as of the date it was uploaded to REGTAP. Links to certain source documents may have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

Exchange Issuer Best Practices 2020

Note: This presentation is based on *Exchange Issuer Best Practices 2019*, available on REGTAP, updated with additional information from the *2019 Federally-facilitated Exchanges (FFE)s and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual*

Exchange Issuer Best Practices 2020

Helping issuers...

- enhance customer service
- process HICS cases accurately
- reduce duplicate work
- continually improve performance

*...through adoption of
best practices.*

Exchange Issuer Best Practices 2020

Outline

- About HICS
- Casework Expectations
- Best Practices
 - In General
 - For Enrollment Blockers
 - For SEP Verification

About the Health Insurance Casework System (HICS)

HICS is the authorized and secure electronic system recognized and used by the Federally-facilitated Exchange (FfEs) to input, track, and monitor qualified individuals' (QIs') and enrollees' concerns, unresolved issues, complaints, and cases that are not able to be resolved by CMS. The FfEs use HICS to appropriately assign unresolved cases and communicate effective date changes to issuers for resolution, when appropriate.

HICS
Health Insurance Casework System

About HICS

In short: the Health Insurance Casework System (HICS) is the official tracking system for Exchange casework.



- Exchange/CMS routes cases to issuers
- Issuers investigate & resolve cases
- Issuers document resolution
- CMS provides technical assistance as needed

About HICS

- Issuers must have adequate staff with access to HICS
 - Sufficient Staff access will aid with individual responsiveness
 - This will help avoid the generation of additional and unnecessary HICS cases
- Staff must be trained to use HICS

About HICS

- Issuers should download the updated guidance on how to access HICS from the QHP website (information found on bottom of the page);
- <https://www.qhpcertification.cms.gov/s/Published%20Guidance%20and%20Regulations>
- Obtain annual recertification for users
- For questions about HICS access contact HICS_Access@cms.hhs.gov

CMS Casework Expectations

- Issuers Monitor HICS daily
- Resolve within required timeframe
- Directive cases contain instructions that *must* be implemented (such as appeals decisions)
- Non-directive cases require review *then* action (such as consumer complaints)
- Records updated only with support of evidence
- Issuer must contact consumer with resolution

Relevant regulation: [45 C.F.R. §156.1010](#)

CMS Casework Expectations

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

Relevant regulation: [45 C.F.R. §156.1010](#)

Best Practices

- Write comprehensive notes
 - ✓ Acknowledge receipt
 - ✓ Briefly restate issue
 - ✓ Include all pertinent case facts
 - ✓ Summarize each step taken
 - ✓ List contacts: Who, When, How, What
 - ✓ Detailed explanation of resolution
 - ✓ How consumer was notified of outcome
- Upload copies of correspondence

Best Practices

It is especially important that resolution notes are more extensive than brief one-liners like: Contact Made, Issue Resolved, and Unable to Contact

Best Practices

- Regular and complete communication with consumers prevents unnecessary repeat HICS cases and reduces case volume.
 - For example, inform consumers how long it will take records to update or for binder payments to process.
- Over the past few years, performance improvement efforts have helped cut in half issuer casework volume and processing times.

Best Practices

- Issuers are encouraged to establish casework goals and milestones for the 2020 plan year for further improvement.
 - For example, an issuer could set a goal to reduce enrollment-adjusted complaint volume by 20% through improved consumer communication and process improvements aimed at increasing initial enrollment accuracy.

Best Practices: Enrollment Blockers

- “Enrollment blocker” is the term for a defect encountered when a consumer submits an updated eligibility application to the Exchange, but a technical issue prevents enrollment data from being updated. The consumer contacts the Exchange call center, which opens a HICS case for issuer action.
- Enrollment blockers may affect changes to:
 - start/end dates
 - incomes
 - APTCs
 - total premium amounts
 - variant IDs/plan IDs
 - demographic data
 - adding/removing covered individuals

Best Practices: Enrollment Blockers

- Certain non-special enrollment period (SEP) change in circumstance (CIC) enrollment blocker cases can be resolved by the ER&R direct dispute process, while others have to be referred to the appropriate CMS regional office for resolution.
- Cases pending with ER&R don't count towards 3 or 15 day resolution timeline until they're returned to the issuer and the clock restarts.
- Issuers with enrollment blocker questions can contact the ER&R Support Center at ERRSupportCenter@Cognosante.com/855-591-7113 or their assigned CMS Caseworker.

Best Practices: Special Enrollment Period (SEP) Verification

- Once their SEP is verified and consumers make a plan selection and pay their premium, consumers are considered enrolled and can start using their insurance.
- The effective date, based on their SEP type and date of plan selection, can be retroactive.
- CMS may use a HICS case to instruct issuers to advance a consumer's start date by one month (from the effective date on the 834 transaction) when Exchange SEP verification significantly delayed the enrollment.

Thanks From CMS

CMS appreciates the continuing effort of the issuer community to promptly address casework matters and to propose HICS enhancements to support excellent customer service.