CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

FAQs for Handling Health Insurance Casework System (HICS) Casework

1. **Does an issuer need to refer a consumer to the Marketplace to create a HICS case when they have been provided enrollment policy or guidance from CMS that can resolve the consumer's issue?**

   No. CMS expects issuers to be consumer's first point of contact for issuer-related matters. As such, when CMS has promulgated policy or guidance, issuers can follow that policy to advise/assist the consumer as appropriate, and note the necessary changes in their internal contact management and/or enrollment systems. Consumers should only be directed to the Marketplace for matters the issuer is unable to or not permitted to address without Marketplace action.

2. **In the recent HICS update, issuers can now note when a case has been referred to the XOSC Help Desk. Is this required?**

   No, issuers are not required to use these fields. However, doing so is strongly encouraged as it will help CMS monitor pending casework as a result of a Help Desk referral.

3. **In a Marketplace presentation on March 13, 2015 (available on REGTAP at https://www.regtap.info/uploads/library/ENR_HHS_EX_SEPEffective_Dates_040315_v1_5CR_040715.pdf), it was mentioned that a new system functionality exists through which CMS is able to adjust effective dates for enrollments that meet qualifying circumstances. CMS indicated that this would reduce the amount of HICS cases requiring issuers to adjust effective dates. However, we have not seen an appreciable decline in HICS cases yet. Is there a problem with this functionality?**

   No. CMS will be working to phase in this functionality over the next several months into its customer service operation. Even when fully implemented, we still believe there will be situations where issuers will be directed via HICS to adjust enrollment effective dates for an existing enrollment or after receiving a new enrollment transaction. All adjustments should be supported by existing policy and/or guidance.

4. **We received a HICS request to reinstate a consumer's enrollment into a Marketplace plan, but the consumer's Marketplace coverage was terminated as a result of a data matching issue. What should we do?**

   For HICS cases where you have not received a new enrollment transaction after the consumer experienced termination of Marketplace coverage as a result of a data matching issue, please advise the consumer to follow the directions in the latest communication he or she received from the Marketplace. After taking this step, the issuer may close the HICS case. The next step for the consumer may be to file an appeal with the Marketplace if he or she believes their Marketplace coverage was terminated in error.

   Consumers with expired data matching issues will need to contact the Marketplace to resolve their data matching issue in order to be eligible to update their enrollment. An issuer should not reinstate Marketplace coverage that has been terminated due to a data matching issue unless the issuer has a new enrollment transaction from the Marketplace. Additional information about data

matching issues can be found in Bulletin #11. Note, the issuer may have a separate obligation under market-wide guaranteed availability and renewability rules to continue the consumer's coverage outside the Marketplace.

5. **What primary resources should issuers use for handling casework?**

   In addition to the regulations in 45 C.F.R. § 156.1010, CMS issued a memorandum providing guidance for handling casework on March 13, 2014 (available here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/casework-guidance- 03132014.pdf. Supplemental guidance is also available in the searchable FAQ database on REGTAP.

6. **What should issuers do with repeat cases from the same consumer relating to the same issue?**

   Issuers should follow the process outlined in the March 13, 2014 casework memorandum. In addition, generally, but not always, CMS will record another HICS case on an identical unresolved matter only after 30 days has passed since the previous case was opened. Exceptions to this rule could be related to a change in a consumer's health status (e.g., a change resulting in a later case being coded urgent). Additionally, issuers are encouraged to contact consumers as soon as possible after receipt of a HICS case, and are required by 45 C.F.R. § 156.1010(d) to contact consumers within 15 days of receipt of a HICS case. Issuers are also reminded that if a consumer has two cases in HICS that are unrelated issues, do not close one of the cases as a duplicate.

7. **Can an issuer add a consumer to an existing enrollment group solely using information in HICS?**

   No, unless CMS provides explicit guidance to do this in very limited instances (e.g. newborn needs to be added to a group and the QHP is suppressed, meaning enrollment capabilities have been suspended).

8. **What should an issuer do if it receives a HICS case that relates to a 2014 1095-A issue?**

   If the case is in the "Plan and Issuer Concerns" category, advise your Lead Caseworker so the case can be reassigned. If the case is in the "1095-A" category, no issuer action is required. The case will be handled by CMS or its contractor.

9. **If an issuer receives a request (inside or outside of HICS) to terminate a 2015 enrollment earlier than the date reflected on the 834, what should the issuer do?**

   The earliest that CMS can approve a termination is no sooner than 14 days from the date the consumer requests the termination. The issuer may, at the consumer's request and the issuer's discretion, effectuate termination in fewer than 14 days, as indicated in 45 C.F.R. § 155.30(d)(2)(iii). However, CMS expects that the issuer's policy in this regard be applied uniformly to all enrollees. If an issuer is unable to accommodate the consumer's request, they should communicate that information to the consumer accordingly.