

Issuer Health Insurance Casework System (HICS) Escalations to CMS

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Presentation Overview

1. Casework overview
2. Types of casework
3. Role of CMS Account Manager/Lead Caseworker
4. HICS case escalation examples*
 - a) SEPs
 - b) Enrollment Blockers
 - c) Cancellation/Termination
5. Questions

* Examples are not all inclusive, but are intended to provide context and general information for Issuers handling HICS casework

HICS Casework

(HICS):

- Official system of record for Federally Facilitated Exchange (FFE) casework
- Categories:
 - Marketplace/ Medicaid/ Children's Health Insurance Program (CHIP) Eligibility
 - Plan and Issuer Concerns
 - Legal and Administrative
 - 1095 Issues

HICS Casework

- In general Exchange casework is an attempt to address an issue or perceived issue by a consumer with their eligibility, enrollment, or plan
- Document, document, document!
- Complete casework means that an independent reviewer can understand what happened with the case by reviewing the documentation. Which should include:
 - Root cause
 - Decisions made
 - Actions taken
 - Enrollment history and/or changes
 - Outcome
 - Consumer communication

Casework Partnership

- **Partner with your CMS Account Manager (AM) and/or Lead Caseworker (LCW)**
 - Unclear case narratives
 - Policy clarifications
 - Missing case information
 - Technical assistance
- **Please don't close cases with “*Issuer unable to update enrollment per CMS policy*”**
 - Get to the root of the issue
 - Explain what policy prevents the requested change
 - We are here to help!
- **Develop a communication process that works for you and your CMS partner(s)**
 - Weekly conference calls
 - Encrypted spreadsheets
 - Emails
 - Ask questions!

Special Enrollment Period HICS Cases (continued)

CFR [§155.420](#) Special enrollment periods.

- Common casework related SEPs:
 - Misrepresentation
 - Error of the Exchange
 - Plan display error
- Effective date changes vary and are unique to each case
- HICS is routinely used to communicate retroactive enrollment effective date changes based on a prospective enrollment

Special Enrollment Period HICS Cases (continued)

Effective Dates continued:

- In general the eligibility for financial assistance (APTC/CSR) from the prospective enrollment should follow the retroactive effective date directed in the HICS case
- If the you as the Issuer believe the effective date listed in the case narrative is incorrect check with your AM/LCW
- Effective date changes directed via CMS Caseworker comments should be honored by the Issuer

Special Enrollment Period HICS Cases (continued)

Issuer actions when enrollment is cancelled/terminated by the issuer for non-payment:

- Issuer research confirms the most recent active selection was cancelled or terminated by the issuer for nonpayment (even if a continuation of the batch auto re-enrollments (BAR))
 - Issuer should review for reinstatement based on policies under the Issuers purview (Issuer error, etc.)
- Issuer research confirms the enrollment is a BAR with \$0 or reduced APTC
 - The issuer should review for reinstatement with the enrollment as-is
 - The consumer will need to appeal for retro-APTC

M834 Guidance: The Continuous Enrollment Test

- If a consumer is terminated for non-payment in Issuer records, and the Issuer subsequently receives an M834 SEP transaction, the following guidance applies:
 - **If there is a gap in coverage** between the termination of the current coverage (meaning the date the APTC grace period ends, if applicable) and the effective date of the change requested by the M834 transaction, the Issuer should accept the M834 as a new enrollment subject to binder (and any past due premium, if the issuer has adopted the policy requiring an enrollee to pay all past - due premiums owed to that issuer for coverage in the 12 months preceding the new coverage's effective date, and previously noticed the enrollee).
 - **If there is no gap in coverage**, the M834 transaction is an update to continuous enrollment and the issuer should not effectuate the termination date change.
 - **The continuous enrollment test is the same for active reenrollments during Open Enrollment (OE) as for SEP transactions outside of OE.**
 - **For more information**, see 7.3.2 and 7.4.3 of the 2019 Enrollment Manual at https://www.regtap.info/uploads/library/ENR_EnrollmentManualForFFEandFF-SHOP_5CR_071019.pdf

Special Enrollment Period HICS Cases

Retroactive Enrollments:

- Generated by CMS/Appeals
 - Often correct errors
 - Can have different APTC/CSR, members, or demographic information compared to prior policies/segments
 - May initiate a new coverage period and/or premium payment grace period
 - May or may not be associated with a HICS case assigned to the associated Issuer
- Generated by consumers or someone acting on their behalf
 - Newborns
 - SEPs added by CMS Caseworkers, but require the consumer to return to the Exchange

Special Enrollment Period HICS Cases

Loss or reduction of Financial Assistance (FA) resulting from expired Data Matching Issue (DMI) or Periodic Data Matching Issue (PDM)

- In general retro FA is not allowed for expired DMIs/PDMs, and consumers should be directed to appeal by you as the Issuer
 - Note that loss of entitlement due to an expired Citizenship/Lawful Presence DMI that is later resolved may involve retroactive SEPs communicated through HICS
 - Loss of FA and loss entitlement SEP policies are different
- However, in a limited number of cases the consumer(s) may have been impacted by an error of the Exchange or misrepresentation
 - Cases directing retroactive FA should result from three sources
 - CMS Caseworker explicate directive comments in HICS
 - Cases generated to adjudicate FFE appeal decisions
 - Explicate and specific directive type HICS case narratives resulting from ad hoc SEPs
 - Look at the details the consumer provided and the CCR entered into the body of the case narrative

Ad HOC SEP Case Narrative

SEP - Consumer is eligible for a retroactive start date. [FIRST NAME] [LAST NAME] lives at [ADDRESS LINE1], [ADDRESS LINE2], [CITY], [STATE] [ZIP], and has a date of birth of [BIRTH DATE]. Consumer enrolled on [ENROLLMENT START DATE] in [PLAN NAME], [PLAN PHONE NUMBER]. The consumer's application ID is [APPLICATION ID]. Information about consumer's issue: [ANSWER 1]. The consumer's requested start date is [ANSWER 2]. Exchange Assigned Policy ID [MGPI]. Last App Updated By: [PARTNER INFO]. Original App Source: [ORIGINAL PARTNER INFO].

Misrepresentation SEP Case Narrative

Consumer attests that **misrepresentation or misinformation** has occurred, which resulted in the consumer not enrolling. **Please verify and determine SEP eligibility.** [FIRST NAME] [LAST NAME] lives at [ADDRESS LINE1], [ADDRESS LINE2], [CITY], [STATE] [ZIP] and has a date of birth of [BIRTH DATE]. Consumer enrolled through Healthcare.gov or other websites. Details regarding what directions the consumer provided: [ANSWER 1]. The individual who failed to follow the request: [ANSWER 2]. Is the consumer eligible for APTC/CSR: [ANSWER 3]. Has the consumer requested a retroactive coverage effective date: [ANSWER 4]. Exchange Assigned Policy ID [MGPI]. Last App Updated By: [PARTNER INFO]. Original App Source: [ORIGINAL PARTNER INFO].

CMS HICS Notes Template- MM Approval

SEP MP Error (correcting existing enrollment start date):

ISSUER ACTION: A SEP has been granted by CMS based upon MP error/misrepresentation. Issuer, you should have a prospective enrollment with an effective date of **XX/XX/XX** via an 834, for Exchange Assigned Policy ID: **XXXXXX** (Segment # **XXXX**). The consumer(s) has been granted a retro SEP back to **XX/XX/XX** for this policy.

- *Please cancel Exchange Assigned Policy ID: **XXXXXX** (Segment # **XXXX**).* Please update your internal systems and make sure that all out of pocket accumulators have been maintained as appropriate. Please update the FFM in accordance with current guidance. **[Caseworker: please only use "cancel" language above only if applicable to your case]**

SEP Cases That Should be Escalated to CMS

- If FFE error/misrepresentation is referenced in the case narrative it should be referred to AM/LCW for review, if no CMS comments are present in the case approving the SEP
- If you can't determine if the case narrative is directive in nature or is a "request"
 - Please note the template shared above includes "requested start date", this does not mean the case is considered a SEP "request"
 - The case may still be a SEP directive to move the enrollment effective date

SEP Cases That Should Not be Escalated to CMS

- Directive language provided to Issuers consistent with approval provided to the Issuer from CMS on Issuer calls
 - Issuer can process case, per directive provided
- HICS cases where the consumer is asking for retroactive FA, not related to misrepresentation or an error of the Exchange
- Rejected or missing enrollment allegations
 - Check your enrollment records, to include pre-audit files
 - If you still don't find it, you should consult with your AM/LCW. An XOSC ticket may be necessary.

Retro APTC - SEP Template

- **SEP - Consumer is eligible for a retroactive start date.**
CONSUMER lives at ADDRESS, and has a date of birth of DOB.
Consumer enrolled on 01/01/2020 in Health Insurance plan (2020),
(877) 687-1196. The consumer's application ID is XXXXXXXXXXXX.
Information about consumer's issue: **Consumer was *not given an APTC when auto-enrolled* into her Health Plan. She discovered this mistake and updated app which applied an APTC for Jan 14,2020 resulting in a financial hardship due to inability to afford billed amount without APTC. The consumer's requested start date is Consumer requests an APTC be granted back to 01/01/2020.** Exchange Assigned Policy ID XXXX46. Last App
Updated By: N/A. Original App Source: N/A.

Retro APTC - SEP Template

- **SEP - Consumer is eligible for a retroactive start date.** CONSUMER lives at ADDRESS, and has a date of birth of DOB. Consumer enrolled on 02/01/2020 in Health Insurance plan (2020), (877) 687-1180. The consumer's application ID is XXXXXXXXXX. Information about consumer's issue: Not Automatically Re-Enrolled in 2020 Coverage Error. **The consumer's requested start date is 01/01 2020.** Exchange Assigned Policy ID 80242825. Last App Updated By: N/A. Original App Source: N/A. **Not Automatically Re-Enrolled in 2020 Coverage Error resulting in plan cancellation because she was *not able to make the full payment without the tax credit.***

Retro APTC – Messaging/Letter

- SEP - Consumer is eligible for a retroactive start date. CONSUMER lives at ADDRESS, and has a date of birth of DOB. Consumer enrolled on 03/01/2020 in Health Insurance Plan(2020) + Vision + Adult Dental, (877) 687-1196. The consumer's application ID is XXXXXXXXXX. Information about consumer's issue: **Consumer has a message on their account that due to Marketplace error the consumer can have their newly updated aptc applied to their plan retroactive.. The consumer's requested start date is 01/01/2020.** Exchange Assigned Policy ID XXXXX47. Last App Updated By: N/A. Original App Source: N/A.

Retro APTC - Messaging/Letter

- SEP - Consumer is eligible for a retroactive start date. CONSUMER lives at ADDRESS, and has a date of birth of DOB. Consumer enrolled on 03/01/2020 in Health Insurance Plan (2020), (833) 709-4735. The consumer's application ID is XXXXXXXXXX. Information about consumer's issue: Check Consumer Messages: **Tax Credit not applied due to error in system, eligible for SEP retroactive start date w/PTC restored.. The consumer's requested start date is 01/01/2020.** Exchange Assigned Policy ID XXXX15. Last App Updated By: N/A. Original App Source: N/A. Consumer Messages show an error in the system caused him to lose his PTC thru no fault of his own. Submitting request per script instructions.

Missing Enrollment - SEP Template

- **SEP - Consumer is eligible for a retroactive start date.** CONSUMER lives at ADDRESS, and has a date of birth of DOB. Consumer enrolled on 01/01/2020 in Health Insurance Plan (2020), (877) 687-1169. The consumer's application ID is XXXXXXXXXXXX. Information about consumer's issue: **Enrollment rejected/not received. The consumer's requested start date is 1/1/2020.** Exchange Assigned Policy ID XXXX07. Last App Updated By: N/A. Original App Source: N/A.

Newborn Slide

SEP - Consumer is eligible for a future coverage start date resulting from a birth, adoption, placement for adoption, or placement in foster care or through a child support or other court order. CONSUMER lives at ADDRESS and has a date of birth of DOB. Consumer enrolled on 01/01/2020 in Health Insurance Plan 11 (2020), (877) 687-1196. The consumer's application ID is XXXXXXXXXXXX. Please adjust the consumer's coverage start date. Type of life change: The consumer enrolled in 2020 coverage on or about mid January 2020 and reported that she was losing Medicaid (due to pregnancy) 1/31/2020. This CSR updated the application to make sure it was reported properly. It set a 1/1/2020 coverage start date. Requested coverage start date: 02/01/2020. Exchange Assigned Policy ID XXXX06. Last App Updated By: N/A. Original App Source: N/A. The insurance company is expecting a payment for January even though **she had Medicaid for the entire month of January and her start date with the Marketplace should be 2/1/2020.**

Newborn Slide - Guidance

- Enrollment Manual pg. 64 (pdf pg. 71)
- Pursuant to 45 CFR §155.420(b)(2)(i), for a QI who gains a dependent or becomes a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, an Exchange must offer coverage **retroactive** to the date of birth, adoption, placement for adoption or in foster care, or the date of the child support or other court order. QIs may also elect a later coverage effective date (either the first of the month following plan selection, or in accordance with paragraph (b)(1)) by calling the Marketplace Call Center.

Medicare Gap, Slide Term - Narrative

- Consumer was removed from Marketplace coverage XXXXXXXXXXXX and other members remain in coverage on the application. **The consumer's intended termination date is 2/29/2020 but functionality limitations provided a termination date of 2/10/2020.** Per CMS guidance provided to issuers, please update the termination date in your system to 2/29/2020 and reconcile with the FFM as appropriate. If the termination date is moved sooner than the original system assigned date, use automated reconciliation. Consumer(s) requesting a new termination date: CONSUMER, N/A, N/A, N/A. Consumer(s) can be reached at PHONE. Exchange Assigned Policy ID XXXXX05. Last App Updated By: N/A. Original App Source: N/A.

Medicare Gap- Slide Term

- The consumer is requesting assistance regarding an erroneous termination due to gaining Medicare coverage which resulted in a gap in coverage.
- Issuers have been instructed to manually adjust the consumer termination dates to the end of the month and report the change in reconciliation.
- Issuers please evaluate and address the consumers issue in accordance with CMS guidance. Generally this means adjudicate the change specified in the HICS case

Voluntary Termination Requests

- A consumer can terminate their Exchange coverage at any time throughout the plan year. However, with the exception of Qualified Dental Partners (QDPs), the termination must be initiated through the Exchange.
- As authorized in regulation, a voluntary termination can take effect immediately from the day the consumer initiates termination or on a future date requested by the consumer.
- While everyone on a policy is eligible for same-day terminations, longstanding operational constraints mean that member level terminations (some but not all are ending coverage) may require the consumer to request a HICS case from the FFE Call Center to adjust the termination date. This is because the system isn't capable of assigning a specific termination date to member level terminations
- **For more information see:**
https://www.regtap.info/uploads/library/ENR_HICStoChangeTerminationDate_080519_5CR_080619.pdf

Retroactive Termination Requests

Does this case require CMS approval?

- Is the termination date consistent with the date of the case or prospective
- Is the termination date retrospective
- If you are unsure contact your CMS AM/LCW
 - Be considerate of your CMS AM/LCW since the FFE has historically received over 100k HICS cases annually related to cancelation/termination requests. In other words we need your help to make sure these are processed in a timely and efficient manner
 - If you don't have a defined process, start by sending a few examples. Please don't send every case you have!
 - Your AM/LCW will work with you to determine what types of cases need to be escalated

Retroactive Termination Requests

- Issuers do not generally have any discretion to offer retroactive termination effective dates unless authorized by CMS guidance.
- Retroactive terminations are currently authorized, with CMS approval, when an error of the Exchange or misrepresentation has occurred on case by case scenario.
 - Examples of errors
 - 500.280 error
 - *Issuer did not receive the 834 transaction from the FFE, but CMS systems reflect the termination attempt*
 - *Enrollee was auto-renewed by the FFE because the enrollee or their assister created an active enrollment using a new “disconnected” application/account*

Retroactive Cancellation/Termination Requests

- **Retroactive cancellation/termination requests are not allowed based on:**
 - Financial hardship
 - Overlapping coverage
 - Consumer negligence
- **HICS cases are assigned to Issuers because you have additional considerations that may impact the ability to enact retroactive cancellation/termination dates in whole or part**
 - Non-payment of premiums
 - Unwanted BAR
 - Duplicative Exchange coverage
- **Retroactive termination requests are not appealable, please don't include appeal language in your resolution notice for these cases**

Retroactive Termination Request Based on Human Error

Marketplace CSR, assister, agent, or broker accidentally terminated consumer's coverage OR set an incorrect termination date. Please consider a special enrollment period to reinstate coverage or set a different termination date for XXXXXXXXXX. Name of consumer(s) who lost coverage: XXX XXXXX, XXXXXX XXXXX. The consumer is requesting to 05/31/2019. Coverage was accidentally terminated on 07/31/2019. If applicable, the consumer(s) request a new termination date of 05/31/2019. The consumer(s) can be reached at (563) 528-3772. Exchange Assigned Policy ID XXXXXX87. Last App Updated By: Insphere Insurance Solutions. Original App Source: Insphere Insurance Solutions. consumer told her agent to end the services for 2019 on 05/31/2019 instead the services were terminated on 07/31/2019 consume would like the 1095 form to be fixed per ISG submit this escalation

Overlapping Coverage

Consumer is requesting a retroactive termination/cancellation date due to **overlapping coverage with a different insurance company**. The consumer's application ID is. Type of overlapping insurance: with a termination date of 12/31/2018 and Kansas Medicaid. Reason consumer has overlapping coverage... **Was approved for Kansas Medicaid with an effective date of November 1, 2018**. Actions taken.... Have terminated the enrollment for effective 12/10/2018. Information of consumer(s) to be made non-applicants: NAME:. Date to set the termination: October 31, 2018. Exchange Assigned Policy ID. Last App Updated By: N/A. Original App Source: N/A.

HICS Case Examples for Retroactive Termination Requests

- In this example, the consumer is requesting a retroactive termination date based on error of the Exchange or misrepresentation on behalf of an individual. The narrative may indicate the consumer has overlapping coverage, but the claimed cause of this is Exchange error or misrepresentation
- This example **requires** the issuer to reach out to their assigned CMS AM/LCW for retroactive termination approval, if not otherwise indicated in the HICS case. The CMS caseworker will research the case and determine if Exchange error or misrepresentation occurred, and return the case to the Issuer if approved.

HICS Case Examples for Retroactive Termination Requests

- “Issuer Action: [Consumer X] requested cancelation or termination more than 30 days ago but the plan has no record of the request. Please investigate and provide the consumer with confirmation of termination, if applicable. [Application ID]. Consumer requested termination date is XX/YY/ZZZZ.”

HICS Case Examples for Retroactive Termination Requests

- In this example the issuer should research their records to determine if the enrollment update was processed in a timely manner. If the Issuer's records were not updated timely, they should do so and resolve the case.
- Issuers generally do not need to reach out to their CMS AM/LCW for technical assistance with this case type
- However, there may be limited circumstances where the case narrative indicates a second possible cause to the delayed termination related. On a case by case basis the Issuer may reach out to their CMS AM/LCW for assistance

Enrollment Blockers

- CMS is evaluating routing all Enrollment Blocker (EB) cases to CMS Caseworkers prior to assigning to Issuers
- The current process involves a daily sort of EB cases by CMS Caseworkers
 - Cases that cannot be initially processed without CMS intervention are pulled back, i.e. demographic changes
 - Cases that can be worked by Issuers, remain with them. i.e. APTC updates
- In addition CMS is reviewing the LOE to add new HICS subcategories, specifically for EB cases

Add a Member

- CMS will process HICS Cases that reference Enrollment Blockers and instruct issuers to add a new member to an existing enrollment group the same way as a demographic change.
- CMS is proactively working addition of member scenarios by CMS Caseworkers generating enrollments.
- Issuers can expect to receive an 834 transaction for addition of member enrollment blocker scenarios.
- If your addition of member scenario has not been addressed by CMS, please notify your CMS Lead Caseworker.

NOTE: Issuers should not contact the ER&R Support Center for missing data elements, as the HICS case is necessary for them to investigate.

Add a Member

Sample HICS Narratives:

- *Consumer was unable to submit application due to error 302100, 500.300588. Make the updates. XXX lives at XXX and has a date of birth of XX/XX/XXXX. Consumer enrolled on XX/XX/XXXX in XXX. The consumer's application ID is XXX. Reason for change in circumstance: change in financial help and added grandson.. Name of new enrollee: XXX. Date of birth/adoption/marriage: NA. Coverage effective date: XX/XX/XXXX. New APTC amount: \$XXX. Cost-sharing reduction variant: Applicant(s): XXX, CSR Variant data not available at this time. XXX, CSR Variant data not available at this time.. Exchange Assigned Policy ID XXX. The consumer added grandson. The consumer will be keeping her same policy and grandson have a new different policy.*
- SEP - Consumer is eligible for a retroactive start date. XXX lives at XXX, and has a date of birth of XX/XX/XXXX. Consumer enrolled on XX/XX/XXXX in Health Insurance Plan(HSA Qualified), (800) 538-5038. The consumer's application ID is XXX. Information about consumer's issue: baby born XX/XX/XXXX they came home about the 16th she called and added the baby to their plan XXX we did not add her now she being billed for all the cost of the birth. The consumer's requested start date is XX/XX/XXXX. Exchange Assigned Policy ID XXX. Last App Updated By: N/A. Original App Source: N/A. She gave birth on XX/XX/XXXX called us about the 16th to have the baby added but they didn't add and now she is being billed for the whole birth she wants it retroactive back to XX/XX/XXXX for the baby

Appeals Related HICS Casework

- Not all appeals are associated with a HICS cases, but if you receive one you must honor it
- You may not always receive a “new” 834 to adjudicate an appeal case. Issuers should follow the directions in the HICS case.
- If the appeal decision is not clear please reach out to your AM/LCW
- Issuers must allow retroactive APTC/CSR even if they consumer previously lost it!
- Consumers are still responsible for their portion of the premium that is not covered by APTC, and must be allowed the appropriate grace period to make premium payments associated with retroactive enrollment actions

Appeals Related HICS Casework

Enrollment changes due to appeal decisions implemented after March of the subsequent year (once data reconciliation and IC834 transaction have concluded for prior year coverage) should be submitted via the ER&R Enrollment Dispute Process (See Section 9.2). These updates will also be noted on the next Pre-Audit file released for the year that the update was made in the FFE. Please refer to the Reconciliation External Calendar for delivery dates of each Pre-Audit file. It can be located at:

<https://zone.cms.gov/document/enrollment-data-reconciliation>.

Questions?

- To Submit or Withdraw Questions by Phone:
 - *If you are listening through your computer speakers and want to submit a question by phone, dial 1-866-391-5945 and enter your unique six-digit PIN, then dial “star(*) pound(#)” on your phone’s keypad.*
 - *If you are already dialed in by phone and want to submit a question, then dial “star(*) pound(#)” on your phone’s keypad.*
 - *If you would like to withdraw a question and you are dialed in by phone, then dial “star(*) pound(#)” on your phone’s keypad.*
- To submit questions by webinar:

Type your question in the text box under the “Q&A” tab and click “Send.”