CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Unauthorized Enrollments: Using the Health Insurance Casework System (HICS)

Center for Consumer Information & Insurance Oversight (CCIIO)

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Presentation Overview

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    - What Issuers must do
    - Benefits of using HICS for UE cases
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Definition of "Unauthorized Enrollment"

- An Unauthorized Enrollment (UE) is an enrollment in a health insurance policy via the Federally-facilitated Exchange (FFE) that was done without the enrollee's knowledge or consent.
- UEs are usually completed by an agent or broker or another person unknown to the consumer who filled out the application and enrolled the consumer(s) in a plan.
- The enrollments may be considered unauthorized if the three criteria are met. (These criteria are discussed in the next section: Current System for Verifying UEs.)
- UEs can result from illegal activity (ID theft or Personally Identifiable Information obtained from a data breach) and/or financial motivations (agents wanting more commissions or collusion schemes among providers).

Definition of "Unauthorized Enrollment" (continued)

Most UEs come to CMS' attention when consumers call the FFE Call Center to complain about:

- Getting mail from an Issuer that is not their health insurance company
- Receiving a Form 1095-A when they did not enroll in FFE healthcare coverage
- Receiving a notice from the IRS that their tax refunds would not be processed until their Advance Payments of the Premium Tax Credit (APTC) are reconciled

These consumers assert that they did not enroll in an Exchange plan or authorize anyone else to enroll them. Many of these consumers already had healthcare coverage or had chosen to go without it.

Prior System for Verifying UEs

Entering cases into HICS

- Most complaints are logged at the FFE Call Center by Call Center Representatives (CCRs); a small number are recorded by CMS staff. Cases are entered into HICS as Category 3 cases (Legal and Administrative) with the subcategory "Alleged Fraud."

  Examples:

  - allegations of unauthorized enrollments
  - misinformation on applications (such as incorrect SSN, income, address, DOB, etc.)
  - marketing scams
  - other potentially fraudulent behavior by agents or consumers

- All Category 3/Alleged Fraud cases are assigned to the Center for Program Integrity (CPI) for review by designating Ellen Witman as the caseworker.

Prior System for Verifying UEs (continued)

Complaints Review and Categorization

- CPI's Complaints Review contractor reads every complaint that is entered into HICS as a category 3 (Legal and Administrative), subcategory Alleged Fraud, and categorizes them in a spreadsheet according to the type of complaint (e.g., unauthorized enrollment, agent/broker misconduct, marketing scam, consumer fraud, etc.)
- All cases tagged as UEs are separated out to be included in an Unauthorized Enrollment Finder File (UEFF). The MIDAS contractor adds additional data about the enrollment (e.g., policy number, policy status, Agent/Broker name & National Producer Number (NPN), APTC amount, duration of policy) to the UEFFs, which are sent to Issuers every few months to review and return to CMS.

Prior System for Verifying UEs (continued)

Criteria for Issuers to Verify

- Issuers are asked to verify whether each enrollment appears to be unauthorized by checking three criteria that would support the claim that the enrollee was unaware of the policy.
  1. No Claims Filed
  2. APTC covered 100% of the premiums or Consumer Responsibility Payment was Not Paid
  3. No Consumer Contact with Issuer (excluding calls to say never enrolled)
- A fourth criteria – that the enrollee actively contacted the FFE and stated that they did not enroll, did not authorize anyone to enroll for them, or did not want or need a health insurance policy through the FFE - is stipulated as true by CMS.
- If all four criteria are met for a policy included in the UEFF file, the Issuer is asked to cancel the policy back to the effectuation date by sending an Inbound 834 with the code CANCL-FRD and to notify CMS by returning the UEFF.

Importance of UE Process

1. CMS informs the IRS of all APTC recipients via the 1095-A reporting process.
2. Consumers enrolled in unauthorized policies with APTC may have significant unwarranted tax liabilities. The IRS may notify them that they must reconcile the APTC amount associated with their FFE policy even if they did not know they were enrolled. If a refund is due, it may be withheld until the APTC is reconciled.
3. A corrected 1095-A can only be issued if the policy is cancelled back to the effectuation date as if it were never in force. The UE process allows Issuers to cancel policies if they verify the criteria that indicate the enrollment was most likely unauthorized.
4. The cancellation automatically generates a corrected 1095-A and the IRS is notified of the change.
5. Cancellation of unauthorized enrollments recoups improperly paid APTC, protecting taxpayers.

Disadvantages of Prior Process

1. Delays sending complaints for verification - Since UEFFs are sent approximately quarterly, complaints that come into the Call Center just after that transmission must wait three (3) to four (4) months until the next UEFF is sent to Issuers, who have six (6) weeks to reply, so HICS cases can wait six months or more to be closed.
2. Consumers are not contacted by CMS - Consumers are not directly notified of the disposition of their cases. If the policy is cancelled a new 1095-A will be sent to the consumer (assuming the contact information is correct). If the policy is not cancelled, the consumer will not know unless she or he contacts the Call Center again and the CCR reads the case closing notes. There is no status report provided during the process.
3. Issuers frequently must use the ER&R process instead of I834 – Because of the delays in getting cases to Issuers, especially in the latter part of the year, the window for submitting Inbound 834s is often closed. (I834 is the preferred enrollment data alignment channel as a cancel reason of fraud can be recorded, which helps with pattern analysis.) Using the ER&R process can also add weeks to the cancellation process, further delaying resolution of the case.

UE Pilot Project: Issuers Receive Cases Directly from HICS (continued)

Process for Sending UE cases directly to Issuers

1. CCRs/CMS Staff still mark cases alleging fraud or misconduct as Category 3/Alleged Fraud and assign to CPI.
2. The CPI Complaints Review contractor still reads and categorizes all complaints.
3. The CPI Complaints Review contractor then separates out the cases categorized as Unauthorized Enrollments and goes into each HICS case to switch the category from Category 3 to Category 2. This sends these cases directly to the Issuers.
4. A note is entered into the "external comments" portion of HICS with instructions to Issuers for processing the case. Additional information that can be used to research the case may also be included if not already in the case description.
5. The caseworker remains Ellen Witman. This should not be changed. CPI sorts and tracks these cases by searching for Ellen's name. In addition to tracking outcomes, the Marketplace Program Integrity Contractor (MPIC) needs to be able to identify these cases for the purposes of data analytics and, if warranted, investigations.

New Process: Issuers Receive Cases Directly from HICS (continued)

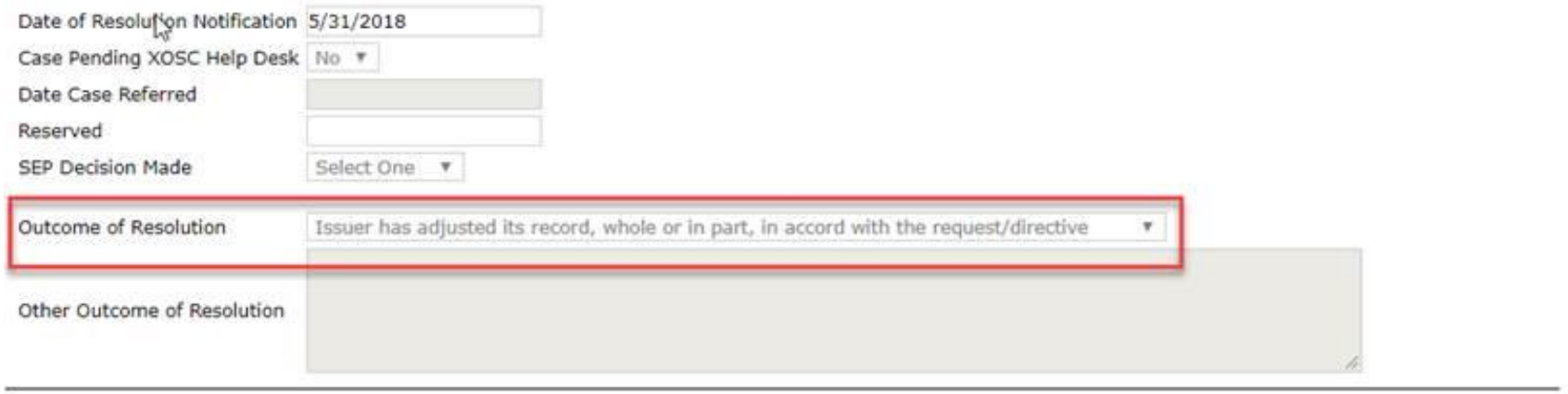
What Issuers receive

- Issuers will receive Category 2 UE cases as soon as they have been reviewed and categorized so that UE cases can be separated from other types of complaints. This process is done at the end of each month and takes approximately a week. Therefore, cases will have a receipt date between one (1) and five (5) weeks prior to the time they are sent to Issuers.
- Simple instructions are uploaded to the "external comments" for each UE case. The instructions include the criteria that need to be verified and directions for indicating to CMS whether or not the policy met the criteria and will be cancelled.
- The information contained in most HICS cases will be available including: the case narrative, consumer's name, DOB, contact information, application number, plan ID (if available), etc.
- Also, at the bottom of the "Case Information" page, in the list headed "Additional Information," the item labeled "Potential Fraud, Waste and Abuse" at the bottom of that list will be marked "Yes."

New Process: Issuers Receive Cases Directly from HICS (continued)

What Issuers must do

- When a HICS case comes to an Issuer, the Issuer should check each policy to see if all three criteria are true and the policy should be cancelled. If one or more of the criteria are not true, the policy cannot be cancelled and will remain in effect.
- Once the Issuer has determined whether or not the policy will be cancelled, that information **must be documented** in HICS by using the "Outcome of Resolution" drop down.



New Process: Issuers Receive Cases Directly from HICS (continued)

- The “Outcome of Resolution” is being used to track whether or not the Issuer verified that the enrollment was unauthorized. If the Issuer cancels the enrollment, it will be assumed the required CMS criteria were met. If the Issuer does not cancel the policy, the criteria that were not met should be noted in the resolution summary.
- The “Outcome of Resolution” choices should be used as follows:
  - **Approved cancellation** - *Issuer has adjusted its record, in whole or in part, in accord with the request/directive*
  - **Denied cancellation** - *Issuer is not permitted to make any requested change(s) according to CMS/issuer policy*

(NOTE: Pending the outcome of the pilot additional HICS enhancements may be enacted to better track UE case outcomes)

New Process: Issuers Receive Cases Directly from HICS (continued)

- All HICS cases must be thoroughly documented per 45 *CFR 156.1010 (g)(2)*. Information about why a policy is not being cancelled (i.e., which criteria were not met) should be entered into the resolution summary.
- For each policy the Issuer will cancel, an Inbound 834 with the cancel code “CANCEL-FRD” must be sent to CMS, if permitted under inbound rules.
- If the policy is for a plan year older than 2018, cancellation must be done via an ER&R Dispute, setting “Prior Year – End Date” to equal the start date of the policy.
- The Issuer must also contact the consumer to report the resolution of the case whether the policy is cancelled or remains in effect.

New Process: Issuers Receive Cases Directly from HICS (continued)

Example Issuer Close Out Note:

As per case narrative member did not live in the state of XXXXX and was enrolled unknowingly. Received Marketplace cancellation request for unauthorized enrollment. Verified that all criteria for rescission due to unauthorized enrollment have been met. Member's coverage in XYZ plan with effective date 10/01/2018 will be cancelled as never in force. No further action permitted by CMS Enrollment Guidance. Member will receive cancellation letter.

Benefits of Using HICS to Resolve Alleged Fraud Cases

1. Issuers receive cases in a more timely manner – within weeks instead of months – and can resolve them quickly.
2. Consumers will be relieved of policies they do not want and did not authorize and will not have significant tax liabilities for APTCs that were attached to the enrollment.
3. Corrected 1095-As will be issued and sent to the IRS, as well as the consumer, after CMS processes the enrollment cancellation. Cancelling policies within the plan year may mean consumers do not have to reconcile APTCs when they file their taxes.
4. Consumers will be notified of the case's resolution by the Issuer.
5. A case record will be maintained in HICS and reports can be produced.

UE Pilot Project Evaluation

CMS conducted evaluations of a UE Pilot Project 30 days and 60 days after the first cases were sent to Pilot Issuers in February 2019 to assess the efficiency and effectiveness of using HICS to resolve cases alleging unauthorized enrollments in QHPs.

- CMS looked at the number of cases sent to each participating Issuer, the resolution rate, the cancellation rate, the reasons for not cancelling policies, and the time it took to research and resolve the cases, among other analyses.
- Issuers participating in the Pilot Project were asked for their feedback on the process, especially regarding sufficiency of data included in case information, adequacy of directions, ease of reporting resolution, overall satisfaction with using HICS vs. UEFF.
- HICS system improvements that would make this process better were also considered.

UE Pilot Preliminary Results

- **CMS' goals are:**
  - Resolve as many of the cases alleging fraud as soon as possible
  - Improve the overall consumer experience
  - Notify consumers of their status and final decisions in a timely manner
  - Reissue corrected 1095-As to relieve tax liabilities consumers should never have had
- CMS believes that using HICS is preferable to the UEFF process for resolving UE complaints.

UE PILOT PROJECT

- CMS appreciates the participation of all the Issuers who agreed to take part in the UE Pilot Project.
- We value your partnership in helping to ensure the integrity of the Federally-facilitated Exchange, protecting consumers and safeguarding federal dollars.

THANK YOU!!

Questions

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