Health Insurance Casework System (HICS) FAQs – August 2015

1. **What should an issuer do if it receives a Health Insurance Casework System (HICS) case with an unclear, incomplete, or contradictory narrative?**

   Because most HICS cases are entered by the Marketplace Call Center only after a consumer indicates that he or she has contacted the issuer first, the issuer should check its internal communication records for additional information that could pertain to its consumer’s case. The issuer should also contact the consumer to get a better understanding of the case.

2. **If an issuer exits a particular service area at the end of a plan year (i.e., the issuer will no longer be offering coverage in that service area for the following plan year), how much time does it have to address unresolved Health Insurance Casework System (HICS) cases from that service area?**

   If a case arises during the original plan year and crosses over into the new plan year, the timeframes specified in 45 C.F.R. § 156.1010(d) still apply to the case. If a case related to a particular plan year arises after that plan year is over, issuers are expected to continue to review and resolve consumer issues after leaving the service area. Additionally, there may be state laws and/or regulations that also articulate an issuer’s responsibility in such cases.

3. **Does the Centers for Medicare & Medicaid Services (CMS) have issuer call center service hour requirements for issuers participating in the Federally-facilitated Marketplace?**

   No. However, issuers are required to satisfy any applicable state requirements. In the absence of state requirements, issuers are encouraged to adhere to standard commercial practices in their geographical area or follow best practice recommendations used in the Medicare program.

   In the Medicare program, during and shortly after the Open Enrollment Period, Medicare Advantage plans operate a toll-free call center for both current and prospective enrollees seven days a week, from at least 8:00 A.M. to 8:00 P.M., according to the time zones for the regions in which they operate. During this time period, current and prospective enrollees are able to speak with a live customer service representative.

4. Does the Marketplace Call Center provide consumers with their Health Insurance Casework System (HICS) case ID?

In instances in which a consumer contacts the Marketplace Call Center to inquire about a HICS case that has been opened but is unresolved, the Marketplace Call Center Representative may provide the HICS case ID. Because of the process utilized to create HICS cases, the Marketplace Call Center is unable to provide a HICS case ID to a consumer upon initial entry of the case. The case ID will begin with the letter “E” and the last two numbers of the year in which the case was recorded.

Issuer customer service representatives should be aware that consumers may be contacting them with follow-up questions regarding their HICS cases, and issuers should address consumer matters appropriately. Consumers have reported that some issuer call center representatives do not know about HICS or fail to recognize the case ID consumers provide, resulting in the consumer being unnecessarily referred back to the Marketplace Call Center.

5. Do the Centers for Medicare & Medicaid Services (CMS) have some suggested best practices for recording Health Insurance Casework System (HICS) case resolution notes?

Yes. Because HICS resolution notes are loaded into the interface used by Marketplace Call Center Representatives daily, and may be read directly to consumers making follow-up inquiries, issuers are encouraged whenever possible to provide complete and clear narratives in plain language that avoid acronyms or technical jargon. For example: “ABC Health Plan has located the consumer’s enrollment into our bronze plan with an 8/1 effective date for the entire household, with a $600 per month tax credit being applied. The consumer will be receiving a welcome packet that includes his or her membership materials and ID card later this week. Resolution letter sent on 6/15/15.” CMS plans to provide further examples of resolution notes for a variety of casework scenarios in the future.

In general, issuers should provide clear resolution notes that provide enough detail to explain how the case was resolved. Simply indicating that the case has been resolved is not adequate. See 45 C.F.R. § 156.1010(g)(2).

6. Does a Qualified Dental Plan (QDP) issuer need a Health Insurance Casework System (HICS) case to terminate a consumer’s enrollment?

No. Based on the Centers for Medicare & Medicaid Services’ (CMS) guidance issued on June 1, 2015, available at QDP issuers can process termination requests when contacted directly by a consumer without a HICS case. Consumers may also contact the Federally-facilitated Marketplace to terminate their QDP, which would result in the termination request coming to the issuer via a HICS case. The guidance is available at: https://www.regtap.info/uploads/library/ENR_QDPTerms_060115_5CR_081815.pdf
7. If an issuer receives a Health Insurance Casework System (HICS) case in which the member has lost eligibility for advance payments of the premium tax credit (APTC) due to an income data-matching issue, subsequently returns to the Marketplace and updates his or her household income information, which restores the member’s eligibility for APTC prospectively, should the issuer provide a retroactive effective date for the restored APTC if the 834 enrollment transaction includes a prospective effective date?

No. Consumers who lose eligibility for APTC due to an expired household income data-matching issue and subsequently update their household income information may qualify for a Special Enrollment Period (SEP) to enroll in, or change, coverage with APTC. However, that SEP will provide a prospective effective date. Consumers do not qualify for a retroactive effective date based only on updated household income information. The issuer should advise the consumer of his or her right to file an appeal of the final eligibility determination notice with the Marketplace.

If a consumer is granted retroactive application of the APTC amount based on an eligibility appeal, the request for retroactive application of the APTC amount will be communicated to the issuer via a HICS case. The HICS case will be recorded in the “Plan and Issuer Concerns” category and the “Eligibility Appeals OHI Related Use Only” subcategory with a narrative that includes the effective date that the issuer should apply. Where a request for retroactive application of the APTC amount is based on an eligibility appeal, the issuer should follow the instructions in the HICS case.

8. Is it true, at this time, that a consumer can add a new email address to receive notifications, but they cannot change the email address that is associated with the Marketplace Account/sign-on?

Yes. The Centers for Medicare & Medicaid Services (CMS) is aware of some functionality issues that may prevent a consumer from updating his or her Marketplace account/sign-on email address if he or she is unable to access that email account due to a lost password, forgotten user name, etc. CMS is working to troubleshoot these situations. In the meantime, the issuer should advise a member in this type of situation that the issuer can update an email that is kept on file to be used for issuer alerts and notifications. The consumer should be advised that his or her Marketplace account is separate from the issuer’s system and is linked to his or her originally-filed application. For information regarding updating that email address with the Marketplace, the consumer will need to work with the Marketplace Call Center and/or access his or her My Account at HealthCare.gov.