DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Casework Guidance for Issuers in Federally-facilitated Marketplaces, including State Partnership Marketplaces

In the Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,[1] the U.S. Department of Health and Human Services (HHS) finalized a rule to be codified at 45 C.F.R. §156.1010 outlining standards for Qualified Health Plan (QHP) issuers in the Federally-facilitated Marketplaces (FFMs) with regard to the resolution of cases. Cases are defined as a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to state or federal laws regulating insurance, concerning the person or entity's activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination.[2] This guidance provides additional information to QHP issuers in the FFMs on casework handling procedures as well as HHS's expectations of QHP issuers operating in the FFMs, including Stand-alone Dental Plan (SADP) issuers.[3] As the FFMs mature, HHS envisions this guidance may be refined to meet evolving program needs and allow HHS to better monitor the consumer experience.

HHS is committed to ensuring QHP issuers in the FFMs provide quality customer service through their telephone customer service lines, websites, and other means. QHP issuers are expected to use appropriate technology and have the infrastructure in place to effectively manage and process consumer inquiries. Pursuant to §156.1010(b), QHP issuers are specifically directed to investigate and resolve a case brought directly by a complainant or the complainant's authorized representative through the QHP issuer's internal customer service process. QHP issuers in the FFMs are expected to train their staff to work with authorized representatives who have submitted the appropriate paperwork. In addition, QHP issuers should not refer consumers and other stakeholders to HHS or the Health Insurance Marketplace (HIM) Call Center for matters that are within their control to resolve. QHP issuers must also ensure that any notices sent to enrollees through the casework process comply with 45 C.F.R §156.250.

In most QHP-related matters, the HIM Call Center and HHS will direct consumers to the QHP issuer to address their concerns, disputes, and grievances. HHS strongly believes the best source

[1] Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals, 78 FR 54070 (August 30, 2013).
[2] Adverse benefit determinations are handled through the internal and external appeals process.
[3] In this document, references to "QHP issuers" include SADP issuers.

for the resolution of issues involving a QHP is the QHP issuer, along with any other appropriate state resource. Consequently, HHS will notify QHP issuers of casework from consumers, providers, and other stakeholders and expects issuers to work in close contact with HHS to facilitate satisfactory resolution of cases within the time periods specified in 45 C.F.R. §156.1010. HHS realizes that some consumers will have already attempted to resolve their matter with the QHP issuer before filing a case with HHS. The HHS casework tracking system will help provide oversight and accountability for QHP issuers, to help ensure that QHP issuers are appropriately responsive to consumer cases. QHP issuers should ensure that their processes for resolving cases forwarded by HHS do not force a consumer or authorized representative who has already contacted the QHP issuer directly to repeat a process that he or she has already completed through the QHP issuer's internal customer service channels. However, HHS will work with consumers and their authorized representatives directly if it becomes apparent that the QHP issuer is not working to resolve the concern, dispute, or grievance pursuant to the regulatory timeframes.

Health Insurance Casework System (HICS)

Pursuant to §156.1010(b), QHP issuers operating in FFMs must investigate and resolve, as appropriate, consumer cases forwarded by HHS. The regulation further specifies that these cases may be forwarded through a casework tracking system developed by HHS, or other means as determined by HHS. On September 4, 2013, CMS notified QHP issuers operating in FFMs that casework will be recorded in the Health Insurance Casework System (HICS), a web application that QHP issuers operating in FFMs are required to use. HICS is used for casework intake and casework resolution activities. HHS also notified QHP issuers that in order to access HICS, they must request and obtain a user ID from the CMS Enterprise User Administration (EUA) system for each individual requiring access to perform casework activities. QHP issuers with experience in the Medicare Advantage and Medicare Prescription Drug Program will find the HICS interface and data extract capability to be similar in many ways to the Complaints Tracking Module (CTM) that is used in those programs.

HICS is accessible to approved users via the following link: https://hics.cms.gov. Users are required to comply with all applicable laws and regulations associated with the use of a government system. Upon log on to the system, in the "Documentation" portion of the system, users can review the "Issuer User's Manual" for technical guidance on how to use the system. It is recommended that QHP issuers have at least two users with HICS access.

QHP issuers that have never applied for HICS access or that currently do not have users registered for HICS access must do so quickly to begin viewing cases that have been assigned to them. QHP issuers can request access by downloading the Application for Access to CMS Computer Systems form from http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf and submitting the original user access form via traceable carrier to:
Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight Room 739H
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HHS generally loads cases originating from the HIM Call Center into HICS every morning, excluding Sundays and some holidays. The cases are loaded from the previous business day. For example, cases received by the HIM Call Center on Tuesday are loaded on Wednesday and cases received by the HIM Call Center on Saturday, Sunday, or holidays are loaded on Monday or the next business day.

Cases assigned to a QHP issuer that are recorded by HHS staff are viewable by the QHP issuer as soon as they are loaded in HICS. Cases are assigned according to the Issuer ID and are only viewable by that QHP issuer.

Questions about HICS access may be directed to HICS_Access@cms.hhs.gov. Technical questions about HICS may be directed to HICS@cms.hhs.gov, with a copy to the QHP's Account Manager and Lead Caseworker.

HHS strongly encourages QHP issuers in the FFM to establish and maintain a close working relationship with their Account Manager and Lead Caseworker to ensure appropriate handling and processing of casework. Lead Caseworkers will serve as the QHP issuer's primary point of contact for individual casework issues. For casework issues that are large in scope or systemic, both the Account Manager and Lead Caseworker should be alerted as soon as the issue is discovered. Both the Lead Caseworkers and Account Managers will review HICS cases and may ask QHP issuers questions relating to cases assigned to them. This could include requesting additional details, documentation, and the identification of a root cause for the complainant's issue. To proactively prevent casework issues, HHS requests QHP issuers advise their Account Manager of planned issuer or plan activities that might generate a significant number HICS cases in a short period of time.

Resolution and Timeliness Standards

All cases recorded in HICS are assigned an Issue Level. Urgent cases are assigned Issue Level 1. Pursuant to §156.1010(e), urgent cases are those in which there is an immediate need for health services because the non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, health or ability to attain, maintain, or regain maximum function, or one in which the process for non-urgent cases would jeopardize a potential enrollee's ability enroll in a QHP through FFMs. In addition, under limited circumstances, HHS may choose to assign a case as Issue Level 1 based on unique characteristics of the case, even if it does not meet the criteria above. These situations include, but are not limited to cases that have been repeatedly brought to the attention of HHS or a state regulatory authority, and other cases as determined by HHS. QHP issuers should treat these cases as Issue Level 1, on the same basis as those urgent cases specified in §156.1010(e). Pursuant to §156.1010(d), QHP issuers in FFMs must resolve urgent cases no later than 72 hours after the case is received by the QHP issuer; a case is considered to have been received by a QHP issuer after it has been entered in HICS and assigned to the issuer. All other cases are assigned Issuer Level 2. Level 2 cases must be resolved within 15 calendar days of receipt of the case by the issuer, as established in §156.1010(d). Where applicable state laws and regulations establish timeframes for case resolution that are stricter than the standards contained in §156.1010, QHP issuers in FFMs must comply with such stricter laws and regulations. QHP issuers are encouraged not to submit requests to HHS to have the Issue Level designation for a case changed.

Regardless of the Issue Level, QHP issuers in FFMs are required to notify complainants (verbally or in writing) about the resolution of the case within three business days after the case is resolved, as required by §156.1010(f). If notification is provided verbally, the QHP issuer also must provide written notice to the complainant in a timely manner. Within seven business days after resolution of the case, the QHP issuer must record in HICS a clear and concise narrative explaining how the case was resolved, including information about how and when the complainant was notified of the resolution. The resolution summary should include any necessary details and supporting materials (e.g., screen shots, letters, transcripts) using HICS's document upload capability when possible.

If a QHP issuer in FFMs receives a second HICS case initiated by a consumer and the prior case concerns the same issue that has already been resolved satisfactorily, the QHP issuer should close the case and note it was a repeat case in the resolution notes. The QHP should verify the consumer has been informed of the resolution by sending a resolution notice. If the first case is still open, but the QHP issuer is working to resolve the matter or has not yet begun to investigate the issue, , the QHP issuer should close the older case, and reference the HICS number of the newer case in the resolution notes. If the first case is a distinct issue from that of the second case, the issuer is to keep both cases open until they are resolved.

HHS recognizes there may be unavoidable situations that prevent QHP issuers in FFMs from meeting the specified time frames in every case. Further, HHS also recognizes the particular need for HHS to work collaboratively with QHP issuers in addressing potential operational issues given that the FFM is in its first year of operations. Therefore, for this first year of operations, QHP issuers operating in FFMs will be considered in compliance with the regulatory requirements for case resolution in 45 C.F.R. § 156.1010 as long as they are making good faith efforts to comply with the regulatory requirements. This includes timely forwarding of issues requiring HHS intervention via HICS or email, assisting the Account Manager and/or Lead Caseworker, and communicating appropriately with complainants and authorized representatives acting on the complainants' behalf. However, HHS generally will not consider a QHP issuer to be making good faith efforts to comply with the requirements where the failure to act within required time frames may jeopardize the health, safety, or life of the consumer. HHS will use HICS data to identify QHP issuers in FFMs with a significant number of cases to discuss steps that can be taken to reduce casework volume and achieve better overall customer service. Although QHP issuers will have up to of 72 hours to resolve an Issuer Level 1 case, HHS staff may seek the assistance of QHP issuers sooner, in limited circumstances, generally limited to cases where there is an immediate medical need.

In situations where research into a portion of a consumer's application or enrollment record is needed to address a casework issue, after thoroughly investigating the case and troubleshooting other potential causes, the QHP issuer should contact the XOSC help desk for further review. This includes instances where: 1) a consumer believes that he or she and/or his or her dependents are enrolled with the issuer, but no record can be found, or 2) a consumer believes that he or she is entitled to an advance payment of the premium tax credit (APTC) but it is not reflected with the enrollment. Cases should be appropriately labelled as pertaining to these specific issues in HICS to ensure timely routing by HHS. Furthermore, in addition to providing the HICS Case ID (when applicable), the QHP issuer is to securely submit via encrypted means, known identifying

information relating to the application/enrollment, including consumer name(s), address(es), date(s) of birth, and telephone number(s).

For situations where a consumer's date of birth requires correction, the QHP issuer should tell the consumer to use the change in circumstance functionality on HealthCare.gov to change the date of birth with the Marketplace. The QHP issuer may receive a new 834 and a term transaction if the changed DOB impacts eligibility.

For all other matters where QHP issuers need HHS staff assistance resolving an individual case, they are to contact their Lead Caseworker via email with the HICS case ID. It is anticipated that a future release of HICS will include an "Issuer Request" feature. Until such time, encrypted email should be used, and under no circumstances should a QHP issuer include personally identifiable information (PII) or personal health information (PHI) in an unsecure email. It is expected that prior to contacting HHS for assistance on a case, the QHP issuer is to exhaust all remedies available to it. QHP issuers are also to contact their Lead Caseworker in the event a HICS case has been accidently assigned to the wrong issuer. A QHP issuer to which a case has been incorrectly assigned should take no action with respect to the incorrectly assigned case apart from contacting the Lead Caseworker, and should cease viewing information in the incorrectly assigned case file until HHS reassigns the case to the correct QHP issuer and removes the material from the original QHP issuer's view.

In addition to other means, HHS may use HICS to communicate important information to the QHP issuer relating to a consumer's enrollment. This could include conveying a CMS decision to grant a Special Enrollment Period or approval of an earlier enrollment date than the QHP issuer may receive on the 834 transaction. In addition, HHS will be making HICS data available to the relevant state departments of insurance (state DOIs), and state DOIs may request that QHP issuers provide them with additional information relating to an individual case. HHS expects QHP issuers in FFMs to respond timely to such requests from HHS and state regulatory authorities.