DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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TO: Issuers of Health Insurance

FROM: Doug Pennington
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SUBJECT: Guidance for Entering Information into HIOS and RBIS

This memo provides issuers guidance and clarification on how to enter certain information into the Health Insurance Oversight System (HIOS) and Rate and Benefit Information System (RBIS).

ASSOCIATION PRODUCTS GUIDANCE

Which association products should be entered during the HIOS Data Collection Window October 3rd - 7th?

Issuers should report all of their association products that meet the updated definition of individual and small group during the October 3rd data collection window. We appreciate that in some instances issuers may need additional time to prepare their association product submissions. CMS may establish additional reporting windows in early November to allow issuers to report on any products that were not included in their October submissions.

Even though all products should be inputted during the first data submission window, if you are unable to accomplish that, we strongly recommend you input products which are likely to have rate increases or renewals occurring sooner inputted during the first window, to assure you do not have plans that are out of compliance with our regulations.

How should issuers enter a product that contains a mix of association and non-association plans?

Issuers should split this product into two separate products: one that contains all of the association plans and one that contains all of the non-association plans. Issuers must mark "Yes" in the association field for the product that contains all of its association plans, and "No" in the association field for the product that contains all of its non-association plans. **Only the non-association products marked as open will be displayed on HealthCare.gov.**

How should issuers enter association products that contain several plan types (i.e. PPO, HMO)?

Issuers with an association product that contains several plan types should mark the **predominant** type in the "product type" field.

Do issuers have to complete all of the fields in the Plan Finder template for association products?

Yes, issuers must complete all fields. Please note that CCIIO is not collecting or displaying number of applications, denials, or up-rates for the Small Group market at this time or planning to use or display it in the known future. Therefore, for Small Group submissions, issuers should enter zero for those three columns. **However, issuers must report enrollment for each small group product.**

HIOS GUIDANCE

How should an issuer treat a product that is sold to individuals, small groups, and large groups?

Under the current Plan Finder reporting requirements issuers must label a product with a mix of small group and individual business as a small group product. Issuers should not report on large group products (the Plan Finder template only allows issuers to label a product as individual or small group). An association product with a mix of individual, small group and large group business should be entered into Plan Finder as a small group product. As appropriate, the issuer should exclude the large group segment of the product in its Plan Finder reporting. Similarly, the rate review reporting requirements only applies to the individual and small group segments of the product.

Who is allowed to attest to the data submitted during the data refresh?

The CEO and CFO are the only individuals allowed to attest to a company's data. If the CEO/CFO is unable to attest for a given reason, a delegate for the CEO/CFO, (i.e. an individual who is designated as a CEO/CFO's stand-in for other business purposes), may attest to the data. Consequently, there should be no alternate designated to attest to a company's data on a permanent basis.

RBIS GUIDANCE

Do issuers need to enter all deductibles options for a product into RBIS?

It is our expectation that issuers report every deductible option for a product. If an issuer has more than 50 different deductible options for a particular product, the issuer should enter the minimum and maximum deductible along with 48 deductible options in increments between the maximum and minimum deductibles. This is the only case in which issuers would not enter all of their deductible options for a product. Please note that here is a character string length limit of 256 for this field.

What level should issuers report deductibles and out-of-pocket maximums?

Deductibles and out of pocket maximums should be reported on the individual level, not the family level.

How do I decide whether to consider a category "covered" or "covered with limitations"?

Reporting for HealthCare.gov should be conducted in accordance with reporting standards for the Summary of Benefits and Coverage requirements which emerge from section 2715 of the

ACA. In general, issuers should report in a manner which represents the predominant business practices associated with that product. General definitions have been provided in Section 17 of the Users' Handbook available on the CCIIO website.

Should the premium data only include medical?

No. If a separate product is sometimes bundled, but exists as a separate product, the premium amounts associated with that other product should not be reported.

How do we report a product whose deductible or out-of-pocket limit is a combination of in-network and out-of-network?

Issuers that offer products with a combined in-network and out-of-network deductible should put the combined value in the in-network deductible field as well as the out-of-network deductible field. Issuers should also put the appropriate duplicate value into the two fields for the in-network and out-of-network out-of-pocket limit.

How does an issuer indicate that they do not cover out-of-network deductible, co-pay, and/or co-insurance?

If an issuer does not cover any of the out-of-network fields (deductible, co-pay, and co-insurance) they should mark "None" in that field. If an enrollee is not required to pay a deducible, co-pay, or co-insurance, the issuer should enter "0" into the corresponding fields.

How should an issuer enter percent co-pay for a PCP visit?

If a product has a fixed co-pay for a PCP visit, an issuer should input that value in the PCP Co-pay field. If there is a percentage that an enrollee must pay for a PCP visit, than an issuer should enter that percentage into the co-insurance field.

How should an issuer report indemnity values for out-of-network fields?

Issuers should enter the same value for in-network and out-of-network fields for indemnity products. For example, the co-pay value should be entered the same in both the in-network and out-of-network fields.

For policy questions regarding the HealthCare.gov Plan Finder, please email CCIIOPlanFinder@hhs.gov.

For technical assistance regarding product-level data submissions, please contact the HIOS Help Desk at 1-877-343-6507 or insuranceoversight@hhs.gov.