Registration

Q: I am an insurer and want to get plan or product information displayed for consumers on the Plan Finder. What is the process?

A: Issuers can access CMS applications, including those for the Plan Finder, through the CMS Enterprise Portal at https://portal.cms.gov/.

Users of CMS applications must complete the Enterprise Portal registration process, which includes identity verification (ID proofing). ID proofing verifies that the individual referenced in the account is the same person creating the account. Once users have completed the registration process and have an account, they will go to the CMS Enterprise Portal and access CMS systems.

You will use the Health Insurance Oversight System (HIOS) to provide insurance company and product information, such as the issuer names, addresses, contact information, and product level data.

You will enter cost-sharing and benefit information in a separate tool—the Rate and Benefits Information System (RBIS), which is accessed using the HIOS system and has the same user ID and password as HIOS. Information you enter into RBIS will appear on the Plan Finder for consumers to review and compare with other plans and products.

Q: I understand that I also need an Issuer I.D.? What is an Issuer I.D.?

A: CMS has defined a structure of identifiers to be associated with issuer data submissions required under the ACA. Issuers represent the organization within an insurance company that is responsible for insurance offerings within a given state. Insurance companies may use different staff or the same staff, but any health insurance company will have one issuer per state in which they are licensed to do business. Registering an entity as an Issuer within HIOS will generate the unique Issuer ID.

Once in HIOS, you will request one or more “user roles,” such as primary data submitter for small group market. The HIOS User Manual provides technical guidance on user management.

Q: When may I enter information into HIOS or RBIS?

A: You may log into HIOS and RBIS at any time except for when they are closed every 10 weeks for a three-week maintenance and enhancement period. These dates are communicated to issuers via weekly calls and memos.

Q: What mechanisms are supported for data submissions?

A: There are three available mechanisms for the issuers to submit their data: Microsoft Excel templates, XSD template for XML submissions and web-entry forms.

The HIOS application works within any of the following compatible Internet browsers:

1. Internet Explorer (version 7 or higher)
2. Mozilla FireFox (version 5 or higher)
3. Chrome (version 9.0 or higher)

Q: Can multiple issuers be in a single ZIP or pipe-delimited file (up to 30 MB)?

A: Yes.

Q: Can the same person upload and validate the data?

A: Yes.

Product and Plan Level Information

Q: What is the difference between a product and a plan as defined in the Plan Finder?

A: A health insurance product is defined as a package of benefits an issuer offers that is reported to State regulators in an insurance filing or the sets of benefits which are associated with various versions of cost sharing, such as deductibles, co-payments etc.

In most states, issuers submit forms identifying the sets of benefits being approved for sale.

A block of business which is sold under that form filing is referred to as an insurance “product.” The identifier for an insurance product sold in a State is the Product ID and it is generated upon submission to HIOS.
Plans are a specific combination of benefits, cost sharing and premium that are offered to consumers. You enter cost-sharing and benefit information in RBIS, which is accessed using the HIOS system. Information you enter into RBIS will appear on the Plan Finder for consumers to review and compare with other plans and products.

Each plan entered in RBIS must match to a product record in HIOS. The product I.D. and the issuer I.D. combine with information at the plan level to create a unique identifier called the Standard Component I.D which maps the combination of specific benefits and cost sharing arrangements sold for a specific price. (Prior to Feb. 2013, this unique standard component ID was called a “Plan Finder I.D.”)

HIOS Data Submissions

Q: What products should I enter into HIOS?

A: All products, whether they are opened or closed for enrollment, should be entered into HIOS. A product not yet approved by your State DOI may be entered into HIOS but must be marked “closed” until it is approved.

The data requirement is for “major medical” products and plans. Examples of basic health services include physician services, inpatient and outpatient hospital services, medically necessary emergency health services, medical treatment and referral services, diagnostic laboratory and diagnostic and therapeutic radiological services, home health services, and preventive health services. The data requirement does not cover supplemental health insurance products.

Q: How is product enrollment defined?

A: Enrollment is defined as “number of people covered to obtain total membership.” For example, if a product is sold to 1 person, but it covers that person and their spouse, enrollment equals 2, not 1.

Q: What is the definition of “effective date” and “expiration date”?

A: Effective start date refers to the first day on which an issuer offers a product to the public. Consequently, the effective end date is the last day on which an issuer offers a product to the public.

Q: Our state operates with a small group definition which differs from that proposed by the Affordable Care Act. How do we report the data?

A: You should report data to the Plan Finder based on the state law and definitions applicable at that time.

Q: When I enter the tools, it asks for my SERFF number? What is a SERFF number and do I have to have one to use the system?

A: The NAIC maintains a reporting service called SERFF which is used by most states and required by 27 states to track submissions from insurance carriers to state DOI commissioners. If your state does not require

participation in SERFF, you are not required to obtain a SERFF number. If you have a product that is associated with a SERFF number, you are required to enter it in HIOS. Although the data collection tool shows the SERFF field as “optional” since many states do not use this system, all existing numbers must be reported.

Q: My company offers the in-network piece of a POS product, but the out-of-network is filed under a separate NAIC code. Should both companies enter these products?

A: We want to show consumers their range of meaningful choices. So this should be represented as one choice and different products. For products which are exclusively parts of POS-combined services, identify the product type as POS, but enter either “in-network” or “out-of-network” in the “Type – Other” field.

Q: If a product is open for enrollment but enrollment is very small, may we mark it as “closed” in HIOS?

A: No. As the documentation notes, this field is intended to differentiate between products closed for enrollment and products that are open for new enrollment.

Q: We have a product line which we are authorized to sell but has never been offered and does not have any enrollment. Do we need to report on this product?

A: You have the discretion to report or not report such products to HIOS.

Q: How do we report enrollment numbers in HIOS?

A: For products reported in HIOS, you are required to report enrollment where it is offered (sometimes called the “situs” level), such as the location of a business offering its employees small group coverage. If you do not collect at the situs level, you may report enrollment by membership residence.

For products reported in HIOS, enrollment numbers represent the total number of covered lives in that product. Enrollment numbers for HIOS should be reported as of the last date of the previous quarter.

Q: Are we required to report formulary and provider network URLs into HIOS?

A: If a provider network and/or formulary list is used to set the base price for your product, then you must report these networks in HIOS in the form of URLs so that consumers may access this information.

Q: Why do I have to report closed blocks that are not accepting new members?

A: You are required to provide information on major medical products in HIOS for which you are licensed to sell in the individual and small group market. CCIIO is including this data to make sure we have a complete picture and are adequately representing the market. For example, because many people are enrolled in closed blocks, it helps account for higher enrollment numbers if you have a significantly smaller number of plans. In addition, a closed block might be reopened in some states.

Closed products will not be displayed online at this point, but we are exploring displaying them in the future if consumers would benefit from comparing open and closed products without introducing a new element of confusion.

You are not required to report Finder products that are closed to enrollment into RBIS.

Q: Do the brochure, formulary and provider network URLs that are entered into HIOS have to be compliant with federal standards for accessibility (508 compliant)?

A: Materials posted on the Plan Finder that can be directly accessed by the public must meet federal accessibility standards. We encourage you to make your data accessible to all users, however, the section 508 law does not apply to private firms which do not receive federal funding and does not extend to links on the Plan Finder to items hosted by your own website.

RBIS Data Submissions

Q: What products or plans should I enter into RBIS?

A: You should only enter plans or products in RBIS that are for sale to the general public and approved by your State DOI.

In order to conform to the 2014 Market Rules, all issuers in all States must submit to RBIS if they offer Individual or Small Group plans. In order to provide issuers with uniform data collection tools, currently, the RBIS data collection utilizes the 2015 QHP Plans and Benefits, Business Rules, Rating and Service Area Templates.

Q: We do not actively market individual plans, but we are required to have a 30-day open enrollment period each year to let anyone into our individual plan. How do we list this type of plan? Do we mark it as “closed” most of the year and then “open” during open enrollment period?

A: Please mark it as open” when it is open for new enrollment and “closed” when it is not open for enrollment.

Q: Why do I enter plan level information into RBIS for the individual and family market and product level information for the small group market?

A: Consumers seeking information about their insurance options for themselves and their families (the individual insurance marketplace) benefit from reviewing the range of benefits and cost-sharing information at the plan level. However, in the small group market, small employers are more likely to offer one insurance product and allow their employees to choose among various cost-sharing options within that product. As a result, for the small group market, insurers enter product level data that shows the set of available deductibles, co-pay amounts, and coinsurance ranges which apply to each product.

Q: I understand that if I submit my plans into RBIS, I may be deemed compliant with the electronic pre-notification requirements of the Summary of Benefits and Coverage (SBC) provisions. How do issuers enter their information for the SBC?

A: The individual/family market RBIS benefits template has fields, including coverage examples information for both maternity and diabetes. The data fields are used to populate a PDF version of the SBC with plan information for consumers to download. You do not have to upload the Uniform Benefit Glossary to be deemed compliant with SBC requirements on HealthCare.gov. The PDF includes a link to the Uniform Benefit Glossary.

Q: In the small group market, are services that have specific limitations or exclusions as part of the broader service category still considered “covered”? Will there be a disclaimer indicating that limitations and exclusions may apply?

A: Under the circumstance, issuers should choose “covered with limitations,” if these limits are outside the generally identified limitations.

Q: For the small group market, are we expected to submit all States on one benefit template or separate templates for each issuer ID?

A: You may do either one.

Q: For ancillary services like dental and vision/eye exams, should we answer in terms of what is a part of our certificate and if those services are a rider to the actual medical plan?

A: You should answer on the basis of the certificate of coverage. If the riders were free to enrollees and applied to all enrollees, then they should be included as covered. However, if they are separate and premium amounts are involved, then the appropriate response would be “covered at extra cost.”

Q: How do we enter small group products that bundle medical and pharmacy coverage? Are we expected to remove the pharmacy portion of the premium?

A: If the products are bundled and there is no separate pharmacy premium, then the pharmacy portion of the premium should not be removed from Total Written Premium.

Plans with Limited or Private Enrollment

Q: Do I need to enter self-funded Multiple Employer Welfare Arrangements (MEWA)?

A: If your MEWAs are regulated by your state insurance department and they offer individual and small group products, we require that a row be entered for the product in HIOS. Identify the type by the drop down box as HMO, PPO, etc. as it applies. Please mark the product as “Association” in the appropriate field, and identify whether it is open or closed for new enrollment.

Q: I have a product which is only offered to members of a specific association (like the Lion’s Club or AARP) in my state. How do I enter these?

A: Enter a row for the product, identify the type by the drop down box as HMO, PPO, etc. as it applies. In the ”Association” field, choose option “Yes.” Also mark whether the product is open or closed for new enrollment. Currently, we are not displaying Association products online.

Q: I have products that are only available to limited populations, such as professional associations, cooperatives, etc. Do those need to be reported?

A: Yes. All major medical products approved for sale in the individual and small group markets are to be reported in HIOS. If a product has plans offered to both the general public and associations, please treat it as you would any other general issuance product. If all the plans under this product are sold only to associations, cooperatives, etc, then you can indicate this by choosing option “Yes” in the “Association” field in HIOS.

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

A: 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.

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

A: Issuers with an association product that contains several plan types should mark the predominant type in the “product type” field.

Q: How should an issuer treat an association product in HIOS that is sold to individuals, small groups, and large groups?

A: Under the current Plan Finder reporting requirements issuers must label an association 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.

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

A: 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.

Q: Do we need to report on Medicare supplements, Medigap policies, accident insurance, single condition coverage, short term or other limited benefit insurance?

A: No. Plan Finder data collections are aimed at gathering comprehensive major medical health insurance only.

Pricing and Benefits Information

Q: How are “base rates” construed for this data collection for the individual market?

A: Base rates for HIOS are being represented as estimates which may change during the underwriting process when health status and pre-existing conditions are factored in. The base rate is the lowest rate before medical underwriting for a person within demographic categories. The base rate should include the cost of coverage for items that are covered or covered with limitations. If an item is not covered or covered for an additional premium, that information should not be included in the base rate for a plan.

Q: What is the Average Cost Per Enrollee for the small group market?

A: For the small group market, issuers use HIOS to report the number of reported covered lives. Our data tools then calculate the per-person cost for the product, which is displayed on HealthCare.gov.

Q: Will total written premium be displayed on HealthCare.gov for the small group market?

A: Total written premium will not be displayed on HealthCare.gov. Total written premium is being collected to calculate the average cost per enrollee, which will be displayed within the HealthCare.gov Plan Finder, corresponding to each small group product represented. The average cost per enrollee is based on one-third of the quarterly premium divided by the enrollment number. Issuers should report the enrollment as of the last day of the reported quarter into HIOS as well as the total written premium during the reporting quarter into RBIS.

Q: How do I decide whether to consider a category “covered” or “covered with limitations”?

A: 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. Any item that is listed as covered or covered with limitations should be included in the written premium for a specific product. If an item is not covered or covered for an additional premium, that information should not be included in the total written premium.

Q: Should the premium data only include medical in RBIS?

A: 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.

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

A: 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.

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

A: 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 deductible, co-pay, or co-insurance, the issuer should enter “0” into the corresponding fields.

Q: How should an issuer enter percent co-pay for a PCP visit in RBIS?

A: 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.

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

A: 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.

Q: If we need to list all deductibles, out-of-pockets, and office visit copays in one cell, are we required to specify the limit for the small group products we submit in RBIS? For example, a $1000 deductible is available only with $5000 out-of-pocket maximum. 90/80 coinsurance is available only with a $6000 deductible. If yes, what is the format?

A: Issuers are not required to identify the specific combinations. List all values for each field and submit a range.

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

A: 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.

Q: If product categories in HIOS are grouped in a broad sense (i.e. including PPO plans currently being marketed on the street for new business along with older PPO policies which groups can renew upon but aren't available to new business), do issuers only input into RBIS the benefit specifics on the actively marketed plans?

A: Issuers should input all benefit information for actively marketed small group products into RBIS. Issuers should be cautious, however, to enter the full written premium, representing every covered life reported in the enrollment for a product (including any open and closed plans within a product).

Q: What level should issuers report deductibles and out-of-pocket maximums in RBIS?

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

Entering Information on Riders

Q: How should riders be entered into RBIS for the small group market?

A: Riders should not be reported in the HIOS product level information. When additional riders are available, the coverage options should be marked as “available at an additional cost.” The collected rider premiums should not be reported.

Data Discrepancies and Corrections

Q: Can you provide additional information on how data discrepancies are verified or corrected?

A: Issuers should review their data in HIOS. If an issuer has identified a data discrepancy between their submitted file and the data displayed in the system, they should contact the HIOS Help Desk. The Help Desk will create a ticket and investigate the root cause of the discrepancy. If the issue is caused by the data submission, the Help Desk will request that the issuer correct their file and resubmit. If the issue is caused by the system, we will be responsible for correcting the issue.

Q: Can errors in HIOS be corrected without having to resubmit the entire data file?

A: It depends on the nature of the issue. If the error has occurred because of a problem in the issuer's data file, then the entire data file must be resubmitted. If the error has occurred because of a defect in our system, we will correct the issue without requiring a revised file submission. Users should contact the Exchange Operations Support Center (XOSC) Help Desk at 1-855-CMS-1515 (855-267-1515) or CMS_FEPS@cms.hhs.gov if they have questions about a particular error.

Q: How does CCIIO ensure that the Plan Finder is consistent with the information provided on states' websites?

A: The Plan Finder links directly to state Medicaid, CHIP and high risk pool web pages. HealthCare.gov also links to InsureKidsNow.gov for CHIP information. In addition, CMS / CMSO works with states to review the information that CMS / CMSO is pulling from federal records about Medicaid and CHIP.

We work with NASCHIP to collect and verify information in cooperation with affected states on the high risk pools. Information on major medical products and plans sold in the individual and small group markets is verified by Issuers who provide the information, and this information is also made available to states if they decide to verify what Issuers report to us.

We welcome feedback from states on these fronts.

Attestation Requirements

Q: When I enter plans in the RBIS, it says they need attestation by the CEO or CFO. What does this refer to?

A: Your company's CEO or CFO (but not both) must attest to the accuracy and to the completeness of your data.

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.

The CEO/CFO attestation language now reads:

By selecting "ATTEST", I agree in my capacity as CEO or CFO that I have examined the small group product submission to the best of my information and knowledge, and I believe it accurately represents the benefit and cost sharing information of the reported products based on current template parameters.

The CEO/CFO attestation applies to an issuer's submission including information submitted for the 1103 requirement associated with HealthCare.gov. They are not attesting as to any additional information regarding rate review filings.

Q: When does the CEO or CFO have to attest to my data?

A: Whenever you make updates during a data submission window.

Additional Questions

Q: Who may I contact if I have a question not answered in the Q&A?

A: To obtain answers about technical questions related to the HIOS System, contact the XOSC Help Desk at 1-855-CMS-1515 (855-267-1515) or CMS_FEPS@cms.hhs.gov.

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