Federal Definitions for Health Insurance Products and Plans

CMS Webinar to States and Issuers

12/27/16

What is a Product?

- A **product** is a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area. In the case of a product that has been modified, transferred, or replaced, the resulting new product will be considered to be the same as the modified, transferred, or replaced product if the changes to the modified, transferred, or replaced product meet the standards of 45 CFR § 146.152(f), § 147.106(e), or § 148.122(g) (relating to uniform modification of coverage), as applicable.

- Any set of plans that share a network type and a set of benefits is a **product.**

- Limitations on benefit coverage, such as limits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the amount, scope or duration of treatment, which specify the scope of benefits covered rather than the health care provider payment portion owed by the consumer, are considered to be features of a product's "discrete package of health insurance coverage benefits" rather than a plan's "cost-sharing structure".

The definitions of product and plan were updated in the Final Rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program* published December 22, 2016. See 45 CFR § 144.103.

Examples of Products

Product A and B differ by benefits covered

Product A and C differ by network type

Product B and C differ by benefits covered and network type

These are all different products and should have unique product IDs in HIOS

	Product A	Product B	Product C
Benefits Covered	Same benefit package as State EHB* Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – with Pediatric Dental (Non-QHP)	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)
Network Type	PPO	PPO	HMO
Plans under Product	Plan A1 – Bronze Plan A2 – Silver Plan A3 – Gold	Plan B1 – Silver Plan B2 – Gold	Plan C1 – Bronze Plan C2 – Silver Plan C3 - Gold

* Essential Health Benefits (EHB)

Examples of Products

If the Issuer wanted to change Product A and provide the same benefits with an EPO network, that would result in a NEW product – Product D, which should have unique product IDs in HIOS.

If the Issuer wanted to offer Product B on the marketplace and submitted its plans for QHP Certification, it would NOT be a different product and Product IDs in HIOS would remain the same.

	Product A	Product D	Product B (Non-QHP)	Product B (QHP)
Benefits Covered	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – with Pediatric Dental (Non-QHP)	Same benefit package as State EHB Benchmark – with Pediatric Dental (QHP)
Network Type	PPO	EPO	PPO	PPO
Plans under Product	Plan A1 – Bronze Plan A2 – Silver Plan A3 – Gold	Plan D1 – Bronze Plan D2 – Silver Plan D3 – Gold	Plan B1 – Silver Plan B2 – Gold	Plan B1 – Silver Plan B2 – Gold

Plan Finder – Product and Plan

- A **product** is a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area. In the case of a product that has been modified, transferred, or replaced, the resulting new product will be considered to be the same as the modified, transferred, or replaced product if the changes to the modified, transferred, or replaced product meet the standards of 45 CFR § 146.152(f), § 147.106(e), or § 148.122(g) (relating to uniform modification of coverage), as applicable.

- For purposes of the Federal Health Insurance Oversight System (HIOS), the identifier for a health insurance product sold in a State is the Product ID, and it is generated upon submission to HIOS. **Plans,** with respect to a product, are the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area that are offered to consumer.
  - Cost-sharing and benefit information is entered into the Rates and Benefits Information System (RBIS), through the HIOS system
  - RBIS information will appear on the Plan Finder for consumers to review and compare
  - Each plan in RBIS must match a product record in HIOS
  - Issuer ID + Product ID combine with information at the plan level to create a unique identifier – the Standard Component ID

The definitions of product and plan were updated in the Final Rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program* published December 22, 2016. See 45 CFR § 144.103.

Product Level Request for HIOS ID

Issuer ID: 11111ST

	Product A – 11111ST001	Product B – 11111ST002	Product C – 11111ST003
Benefits Covered	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – with Pediatric Dental benefits (non-QHP)	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)
Network Type	PPO	PPO	HMO
Plans under Product	Plan A1 – Bronze – 11111ST0010001 Plan A2 – Silver – 11111ST0010002 Plan A3 – Gold – 11111ST0010003	Plan B1 – Silver – 11111ST0020001 Plan B2 – Gold – 11111ST0020002	Plan C1 – Bronze – 11111ST0030001 Plan C2 – Silver – 11111ST0030002 Plan C3 – Gold – 11111ST0030003

A 3-digit code is added to the Issuer ID to get the Product ID: 11111ST001

A 4-digit code is added to the Product ID to get the Plan ID: 11111ST0010001

Is it a Product or a Plan?

- Gold, Silver, and Bronze metal levels are determined by cost share differences only
- Benefits covered are the same
- Network type is the same

These are not different products, but rather different plans under the same product.

These are the same product; just different plans			
	Plan A	Plan B	Plan C
Benefits Covered	Same benefit package as State EHB Benchmark	Same benefit package as State EHB Benchmark	Same benefit package as State EHB Benchmark
Network Type	PPO	PPO	PPO
Metal Level	Gold	Silver	Bronze

What is a Plan?

- A **plan** is the pairing of the health insurance coverage benefits under a product and a particular cost-sharing structure, provider network, and service area
- The **product** comprises all **plans** offered within the product
- The combination of all service areas of the **plans** offered within a **product** constitutes the total service area of the product
- **Plans** within a product can vary based on cost sharing structure, provider network, and service area

Examples of Plans

	Product A	Product B	Product C
Benefits Covered	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – pediatric dental (non-QHP)	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)
Network Type	PPO	PPO	HMO
Plans	Plan A1 – $2,000/$3,000 indiv/fam deductible; pays 60% of covered services Plan A2 – $1,500/$2,225 indiv/fam deductible; pays 70% of covered services Plan A3 – $1,000/$1,750 indiv/fam deductible; pays 80% of covered services	Plan B1 – $1,500/$2,225 indiv/fam deductible; pays 70% of covered services Plan B2 – $1,000/$1,750 indiv/fam deductible; pays 80% of covered services	Plan A1 – $2,500/$4,000 indiv/fam deductible; pays 65% of covered services Plan A2 – $1,500/$2,500 indiv/fam deductible; pays 75% of covered services Plan A3 – $500/$1,000 indiv/fam deductible; pays 85% of covered services

Example of Service Area Determination

	Product A – service area A,C,D,E,F,G,L,X,Z	Product B – service area A, B, C, D, K, L, N, Q	Product C – service area A - Z
Benefits Covered	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)	Same benefit package as State EHB Benchmark – pediatric dental (non-QHP)	Same benefit package as State EHB Benchmark – no pediatric dental (QHP)
Network Type	PPO	PPO	HMO
Plans	Plan A1 – $2,000/$3,000 indiv/fam ded; plan pays 60; service areas: A, D, E Plan A2 – $1,500/$2,225 indiv/fam ded; pays 70%; service areas C, F, G, L, X, Plan A3 – $1,000/$1,750 indiv/fam ded; pays 80%; Service areas A, C, X, Z	Plan B1 – $1,500/$2,225 indiv/fam ded; pays 70; service areas: A, B, C, D Plan B2 – $1,000/$1,750 indiv/fam ded; pays 80%; service areas A, B, K, L, N, Q	Plan A1 – $2,500/$4,000 indiv/fam ded; pays 65%; service areas: A - L Plan A2 – $1,500/$2,500 indiv/fam ded; pays 75% Plan A3 – Gold: service areas A - N Plan A3 – $500/$1,000 indiv/fam ded; pays 85%; Service areas; A – Z

Who to Ask in CCIIO

Questions related to HIOS IDs are to be directed to:

Brian James, Division Director, Non-Exchange Insurance Issuer Data Collection
email: Brian.James@cms.hhs.gov
work phone: 301-492-4234

Questions related to Uniform Rate Review Template and Actuarial Memorandum submissions are to be directed to:

Brent Plemons, Deputy Director, Rate Review Division
email: Brent.Plemons@cms.hhs.gov
work phone: 301-492-4120

Questions related to Direct Enforcement Form Filing submissions are to be directed to:

Mary Nugent, Deputy Director, Compliance and Enforcement Division
email: Mary.Nugent@cms.hhs.gov
work phone: 410-786-8816

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Questions