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## Uniform Modification and Plan/Product Withdrawal FAQ

June 15, 2015

### **Q1: An issuer stops offering Product X at the end of 2015, and in 2016 begins offering Product Y. Is Product Y a new product?**

It depends. If the differences between Product X and Product Y qualify as a uniform modification of coverage, then, for purposes of federal law, Product Y is not a new product. Rather, it is a continuation of Product X (even if a new Product ID has been assigned by the issuer), and it should be reviewed as if it is the same product, including with respect to rate review. Only if the changes are outside the scope of changes contemplated by the uniform modification rules would, for purposes of federal law, Product X be considered to have been discontinued, and Product Y be considered a new product. HHS guaranteed renewability regulations at 45 CFR 146.152, 147.106, and 148.122 set forth standards for uniform modifications of coverage and discontinuation of a product (as defined in 45 CFR 144.103).<sup>1</sup>

For example, Issuer offers Product X in the individual market in 2015 (Product ID: 39854QQ042). Issuer stops offering Product X effective at the end of 2015, and, for 2016 coverage, begins offering Product Y (Product ID: 39854QQ043). The only changes between Product X and Product Y are cost-sharing changes to maintain metal tier levels for each Plan in the Product. For purposes of federal law, Product Y is not a new product because the changes satisfy the conditions of a uniform modification of coverage – they are cost-sharing changes made to a plan to maintain the same metal tier level.<sup>2</sup>

The uniform modification rules give issuers substantial room to adjust product portfolios. Changes to covered benefits, outside of those made pursuant to applicable federal or state requirements, may cumulatively impact the plan-adjusted index rate for any plan within the product by  $\pm 2$  percentage points without falling outside the scope of the uniform modification of coverage rules. In addition, under 45 CFR 147.106(e)(4), regulators may broaden standards relating to service area and cost-sharing structure, giving issuers room to adjust plans within products, and stay within the parameters for

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<sup>1</sup> HHS regulations at 45 CFR 146.152, 147.106, and 148.122 contain parallel provisions relating to guaranteed renewability of coverage and the exceptions for uniform modification of coverage and discontinuance of a particular product or all coverage in the market. For simplicity, when referring to the guaranteed renewability exceptions for uniform modification, product discontinuance, and market withdrawal, these FAQs refer only to the provisions codified at §147.106, but should be considered to include references to the applicable paragraphs of all three regulations.

<sup>2</sup> 45 CFR 147.106(e)(3)(iv).

uniform modification. If product changes fall within the uniform modification standards, including pursuant to the state discretion under 45 CFR 147.106(e)(4), the product is subject to the ACA rate review requirements under 45 CFR Part 154 as a continuation of the product that was modified. CMS encourages states to exercise this discretion to ensure that product changes are considered uniform modifications of coverage where appropriate.

**Q2: An issuer makes changes within a product but submits it as a new product. The state determines that the product changes are within the standards for uniform modification of coverage. Is the issuer required to revert to the product's former Health Insurance Oversight System (HIOS) product identifier (ID)?**

HIOS product IDs should change only when a new product is being submitted, as determined by the uniform modification of coverage standards. If a product remains the same product, consistent with the uniform modification standards, it should continue to use the same HIOS product ID. If a product is a different product based on the uniform modification standards, the new product should use a different HIOS product ID.

However, for products that will be offered for plan years beginning in 2016, issuers that submitted product IDs in a manner inconsistent with this guidance will not be expected to update their HIOS product IDs, unless otherwise required by the applicable state regulator. Nonetheless, we note that the HIOS ID assigned by the issuer is not determinative of compliance with any applicable provision of federal law, including the guaranteed renewability and rate review requirements. The discrete package of health insurance coverage benefits that the health insurance issuer offers using a particular product network type within a service area comprising the product, rather than the HIOS ID, will determine an issuer's obligations under those provisions of federal law.

For example, as discussed in Q&A-1, Issuer offers Product X in the individual market in 2015 (Product ID: 39854QQ042). Issuer stops offering Product X effective at the end of 2015 and, for 2016 coverage, begins offering Product Y (Product ID: 39854QQ043). The only changes between Product X and Product Y are cost-sharing changes to maintain metal tier levels for each Plan in the Product. For purposes of federal law, Product Y is not considered a new product because the changes satisfy the conditions of a uniform modification of coverage – they are cost-sharing changes made to a plan to maintain the same metal tier level. In this example, under this guidance the issuer would otherwise be directed to maintain the same Product ID for Products X and Y, but for 2016, CMS will not require the issuer to revert back to the 2015 product ID (Product ID: 39854QQ042).

**Q3: If an issuer removes a plan from a product or adds a plan to a product, would such a change be considered a discontinuance of that product?**

An issuer will not trigger a product discontinuance by removing a plan from a product or adding a plan to a product, unless by removing a plan, the issuer exceeds the scope of a uniform modification for the product (e.g., the product no longer covers a majority of the same service area).

For example, Issuer offers Product X in a state that defines service area based on enrollment-weighted geographic coverage. Product X includes 3 Plans – Bronze Plan X (constituting 20 percent of the product’s enrollment), Silver Plan X (constituting 75 percent of the product’s enrollment), and Gold Plan X (constituting 5 percent of the product’s enrollment). Issuer removes Bronze Plan X. The removal of Bronze Plan X can be considered a uniform modification of Product X under 45 CFR 147.106(e)(3), which does not result in the discontinuance of Product X because Product X continues to cover a majority of the same service area based on covered population.

**Q4: If an issuer makes minor changes to a plan’s cost sharing, has it changed the plan’s “cost-sharing structure” such that the change will not be considered a uniform modification, and a product discontinuance is triggered under 45 CFR 147.106(e)(3)(iv)?**

Because the regulations do not define the term “cost-sharing structure,” CMS will defer to a state’s reasonable interpretation of this provision. Furthermore, a state has the discretion to broaden the standards in 45 CFR 147.106(e)(3)(iv), as stated in 45 CFR 147.106(e)(4), such that changes in cost sharing within the same metal tier level could be considered a uniform modification rather than a product discontinuance. CMS intends to be flexible when determining whether a cost-sharing structure is “the same” for the 2016 plan year as it was in the 2015 plan year. Note that the magnitude of a change in cost-sharing structure does not affect whether the change is considered a uniform modification if the change was solely related to changes in cost and utilization of medical care, or to maintain the same metal tier, as set forth in 45 CFR 147.106(e)(3)(iv). Any changes in cost-sharing structure for such reasons would be considered a uniform modification that would not trigger a product discontinuance.

**Q5: If an issuer changes all of its products in a market such that the changes do not qualify under the uniform modification rules (resulting in a product discontinuance), will the issuer be considered to have performed a market withdrawal, and be subject to the 5-year prohibition on market reentry?<sup>3</sup>**

Yes. For purposes of federal law, market withdrawal occurs when a carrier discontinues all of its products<sup>4</sup> within the applicable market in a state (individual market, small group market, or large group market). This is true even if a carrier files new products, if those new products would not be available for coverage effective until after the current products are discontinued. Therefore, if an issuer’s entire offering of products within a market has been discontinued or substituted with new products such that each substituted product has undergone changes that are not uniform modifications, then the issuer has effectuated a market withdrawal under federal law, and will be subject to the five-year prohibition on market reentry, beginning on the date of discontinuation of the last coverage not renewed. Therefore, the issuer will be prohibited from offering the

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<sup>3</sup> 45 CFR 147.106(d)(2)

<sup>4</sup> Product means a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area. 45 CFR 144.103.

newly filed products. The issuer would be required to provide notice of the discontinuation at least 180 days prior to the date coverage would be discontinued.<sup>5</sup>

Because product filings for coverage beginning in 2016 already have been filed in many states, CMS will apply this policy prospectively, effective for coverage beginning on or after January 1, 2017.

If, however, the changes to any product are determined to include only uniform modifications, then those changes would not result in the discontinuance of the product, and the continuation of that product would mean that the issuer did not effectuate a market withdrawal. States have the discretion to broaden the scope of what is considered a uniform modification with respect to the service area and cost-sharing structure.<sup>6</sup>

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<sup>5</sup> See 147.106(d).

<sup>6</sup> 45 CFR 147.106(e)(4).