

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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June 11, 2015

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House, Room H-107
Annapolis, Maryland 21401-1991

The Honorable Thomas M. Middleton
Chair, Senate Finance Committee
Miller Senate Office Building
11 Bladen Street, 3 East Wing
Annapolis, Maryland 21401-1991

The Honorable John C. Astle
Vice Chair, Senate Finance Committee
James Senate Office Building
11 Bladen Street, Room 123
Annapolis, Maryland 21401-1991

The Honorable Catherine E. Pugh
Chair, Senate Finance Health Subcommittee
Milder Senate Office Building
11 Bladen Street, 3 East Wing
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker of the House
State House, Room H-101
Annapolis, Maryland 21401-1991

The Honorable Peter A. Hammen
Chair, HGO Committee
House Office Building
6 Bladen Street, Room 241
Annapolis, Maryland 21401-1991

The Honorable Shane E. Pendergrass
Vice Chair, HGO Committee
House Office Building
6 Bladen Street, Room 241
Annapolis, Maryland 21401-1991

RE: Selection of the 2017 Benchmark Plan
MSAR #10543

Dear Ladies and Gentlemen,

In accordance with Section 31-116 of Senate Bill 556, Chapter 363, Acts of 2015, the Maryland Insurance Administration (“MIA”), in consultation with the Maryland Health Benefit Exchange (“MHBE”), was tasked with selecting the 2017 Benchmark Plan. The 2017 Benchmark Plan will

be used to determine the essential health benefits required in every non-grandfathered health benefit plan issued or renewed in the individual and small employer markets on and after January 1, 2017. After making the selection, the Commissioner was to advise the Senate Finance Committee and the Health and Government Operations Committee of the Commissioner's selection and the process used in making the selection.

Identification of the Plan Options for 2017 Benchmark

Section 31-116 (c)(1) of Senate Bill 556 requires that the 2017 State Benchmark Plan be selected from the largest small group health plan by enrollment in any of the three largest small group products by enrollment. Federal guidance indicated that the 2017 State Benchmark Plan should be based on enrollment from plans offered during the first quarter of 2014. On April 17, 2015, the MIA issued a data call to assist in identifying the largest small group products and plans by enrollment for the first quarter of 2014. The MIA received the completed data call from all the small group carriers and analyzed the data call results. The largest plans in the three largest products were identified as the following:

- Largest Product ===>Largest plan within the product===>BlueChoice HMO HSA/HRA \$1,500
- Second Largest Product ===>Largest plan within the product===>BlueChoice HMO Referral \$30/\$40
- Third Largest Product ===>Largest plan within the product===>United Healthcare Insurance Company PPO plan

All of the plans that were identified were non-grandfathered health benefit plans, which contained all of the essential health benefits required by the Affordable Care Act (“ACA”).

Description of Plans and Requirements

In accordance with Section 31-116(d) of Senate Bill 556, when selecting the 2017 State Benchmark Plan the Commissioner, in consultation with the Maryland Health Benefit Exchange, “shall:

- (1) select a plan that complies with all requirements of this title and the Affordable Care Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and any other federal laws, regulations, policies, or guidance applicable to state benchmark plans and essential health benefits;
- (2) for individual health benefit plans, require that the health benefit plans include any mandated benefits that were required in individual health benefit plans before December 31, 2011, if the benefits are not included in the selected benchmark plan; and
- (3) if the selected state benchmark plan does not comply with any federal benefit requirement, supplement the required benefits, to the extent permitted by federal law, with benefits similar to those chosen by the Maryland Health Care Reform Coordinating Council in 2012.”

Hearing and Written Comments

Section 31-116(c)(1) required that the 2017 State Benchmark Plan be selected through an open, transparent, and inclusive process, which should include at least one public hearing and an opportunity for public comment. Accordingly, on May 4, 2015, the MIA held a public hearing for the selection of the 2017 Benchmark Plan at 10 a.m. at the MIA offices. Oral testimony was accepted in person and by phone during the hearing. Written testimony was also accepted until 5 p.m. on Thursday, May 14, 2015.

Oral testimony was received from the following persons:

- Patricia O'Connor – Health Education and Advocacy Unit, Office of the Attorney General
- Leni Preston – Maryland Women's Coalition for Health Care Reform¹
- Ellen Weber – Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law¹

Written comments were received from the following entities:

- Deborah R. Rivkin – CareFirst BlueCross BlueShield
- Abe Saffer - American Diabetes Association
- Judith Page - American Speech-Language-Hearing Association
- Robyn Elliott - Public Policy Partners
- Jeff Album - Delta Dental
- Leni Preston- Maryland Women's Coalition for Health Care Reform
- Ellen Weber.- Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law
- Peter Thomas - Habilitative Benefits Coalition
- Gloria Petit-Clair - Maryland American Speech-Language-Hearing Association
- H. Angela Mezzomo - Maryland Speech-Language-Hearing Association

The written comments are found as appendices to this report. The only entities who recommended one of the plans as the 2017 Benchmark Plan were Deborah R. Rivkin, representing CareFirst BlueCross BlueShield, Jeff Album, representing Delta Dental, and Leni Preston, representing the Maryland Women's Coalition for Health Care Reform. All of these entities recommended the CareFirst BlueChoice HMO plan as the 2017 Benchmark Plan. Those who recommended the CareFirst BlueChoice plan other than Deborah R, Rivkin, of CareFirst BlueCross BlueShield, indicated that their recommendation was based on the specificity of the text in the CareFirst BlueChoice contracts, rather than on any distinct difference between the CareFirst BlueChoice plans and the United Healthcare Insurance Company PPO plan.

Selection of the 2017 Benchmark Plan

Staff from the MIA and the MHBE reviewed the contracts for each of the largest small group plans by enrollment, along with the comments from all the entities who provided oral or written testimony. All of the small group plans under consideration were non-grandfathered health

¹ Written comments were also provided.

benefit plans, which contained all of the essential health benefits required by the ACA. The two CareFirst BlueChoice, Inc. contracts were identical, with the exception of cost sharing and gatekeeper requirements, neither of which impact the essential health benefits of the benchmark plan. The United Healthcare Insurance Company PPO plan contained different text, but the same essential health benefits as the CareFirst BlueChoice, Inc. contracts.

Many of the written comments included criticisms about particular provisions found in the particular plans. A number of the written comments noted that the definition of habilitative services was changed at the federal level since the date the 2014 contracts were approved and requested that the selected benchmark plan be amended to comply with the new federal requirements. Others commented about limitations in the contracts that they believed were discriminatory, such as the age 18 limitation for hearing aids. Still others noted particular text in plans that they believed did not comply with the Mental Health Parity and Addiction Equity Act and requested amendments of the benchmark plan. However, the benchmark selection process does not include amending the selected plan. Under both federal regulations² and Maryland law,³ the selected plan may only be supplemented if the plan is missing an essential health benefit. Since none of the three plans under consideration was missing any of the essential health benefits, no supplementation is required or permitted.

While the selection process does not permit amendments to the selected benchmark plan, the federal authorities have made it clear in conference calls with the states, that states are expected to enforce the federal requirements regarding essential health benefits, including requirements regarding habilitative services, discriminatory benefit design, and the Mental Health Parity and Equity Addiction Act. The comments that were received have been incorporated into the MIA review of plans for 2016, as applicable.

After reviewing all the comments and consulting with the Maryland Health Benefit Exchange, the CareFirst BlueChoice HMO HRA/HSA \$1500 plan, the largest plan in the largest product by enrollment in the first quarter of 2014, has been selected as the 2017 Benchmark Plan for Maryland. Information regarding this selection was communicated to the Center for Consumer Information and Insurance Oversight with the Department of Health and Human Services on June 1, 2015.

Sincerely,
Signature on original

Al Redmer, Jr.
Insurance Commissioner

cc: Senate Finance Committee Members
House Health and Government Operations Committee Members
Victoria L Gruber, Esq., Chief of Staff (President)
Kristen F. Jones, Esq., Chief of Staff (Speaker)

² 45 C.F.R. 156.110(b).

³ Insurance Article, § 31-116(d)(3).

cc: Patrick D. Carlson, Committee Staff (Finance)
Linda L. Stahr, Committee Staff (Health and Government Operations)
Carolyn Quattrocki, Executive Director, Maryland Health Benefit Exchange
Nancy J. Egan, Director of Government Relations
Sarah T Albert, Department of Legislative Services (5)

APPENDICES

- Appendix 1: CareFirst BlueCross BlueShield
- Appendix 2: American Diabetes Association
- Appendix 3: American Speech-Language-Hearing Association
- Appendix 4: Public Policy Partners
- Appendix 5: Delta Dental of Pennsylvania
- Appendix 6: Maryland Women's Coalition for Health Care Reform
- Appendix 7: Drug Policy and Public Health Strategies Clinic of the University of Maryland
Carey School of Law
- Appendix 8: Habilitation Benefits Coalition
- Appendix 9: Maryland American Speech-Language-Hearing Association State Advocate for
Reimbursement
- Appendix 10: Maryland Speech-Language-Hearing Association

Appendix 1

CareFirst BlueCross BlueShield

Deborah R. Rivkin
Vice President, Government Affairs - Maryland

CareFirst BlueCross BlueShield
Mailstop CT10-04
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981



May 14, 2015

Mr. Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Mr. Cavey:

I am writing on behalf of CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. (CareFirst), in follow up to my letter dated April 30, regarding the Maryland Insurance Administration's designation of Maryland's 2017 essential health benefit benchmark plan. After our April 30 letter was submitted, the MIA released the three options for consideration for the benchmark plan. This letter is to follow up with our views on the options presented.

We have maintained that the MIA should choose the plan that would pose the least disruption to the market, as any significant changes to the benchmark plan would result in a significant administrative burden for all carriers with no change to consumers. The two BlueChoice plans that are included in the options released by the MIA offer the same benefits that are offered in the current benchmark plan today. The only meaningful difference between these two plans is in cost sharing. The plan most closely resembling the current benchmark plan with regard to cost sharing is the BlueChoice HMO HSA/HRA \$1,500. As a result, we recommend that the MIA designate the BlueChoice HMO HSA/HRA as the benchmark plan for 2017, with our second choice being the BlueChoice HMO Referral \$30/\$40.

Sincerely,

Signature on original

Deborah R. Rivkin

Deborah R. Rivkin
Vice President, Government Affairs - Maryland

CareFirst BlueCross BlueShield
Mailstop CT10-04
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981

April 30, 2015



Mr. Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: Public Hearing for Selection of 2017 Benchmark Plan

Dear Mr. Cavey:

I am writing on behalf of CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc. and CareFirst BlueChoice, Inc. (CareFirst) concerning the Maryland Insurance Administration's (MIA) determination of Maryland's 2017 essential health benefit benchmark plan and the subsequent 2017 benefits that will be required for individual and small employer health insurance plans in Maryland. CareFirst strongly supports maintaining a consistent set of benefits from year to year to limit market disruption and ensure that the comprehensive coverage members receive today continues in the future.

As you know, on April 8, 2015, the Centers of Medicare and Medicaid Services (CMS) released a list of the largest three small group products ranked by enrollment in each state to help facilitate their selections of benchmark plans for the 2017 plan year. We understand that since the release of the list, there have been numerous issues identified nationally with the listed plans not accurately representing the top three small group plans by enrollment. For example, some states have indicated that the plans listed are catastrophic plans, which are highly unlikely to have the largest enrollment, whereas others have noted that some insurers reported plan enrollment at the product and not plan level, thereby skewing results. Several state insurance regulators therefore, have asked carriers to independently verify their Affordable Care Act (ACA)-compliant small group plan by enrollment to ensure that the selection of the 2017 benchmark plan is accurate and reflects the plan selection consumers actually made and preferred, including the regulators in the District of Columbia and the Commonwealth of Virginia, and, most recently, the MIA.

Changing the benchmark plan from the current plan will be an enormous undertaking for all carriers that will require a redesign and reconfiguration of SBCs, templates, the redrafting, filing and approval of member contracts, expensive systems and operational changes and template changes for the Maryland Health Benefit Exchange among other things. Accordingly, CareFirst strongly urges the MIA to ensure that its selection of the 2017 benchmark plan is based on accurate and verifiable information that is consistently provided across carriers before any change to the existing benchmark plan is made. Given

the variability in the marketplace around the definition of products and plans, we encourage the MIA not to make any changes to the benchmark plan unless its analysis clearly compares ACA-compliant plans (not products) sold in the first quarter of 2014 and the results of such analysis require a change.

Thank you for the opportunity to comment on the benchmark plan selection. If you have any questions, please feel free to contact me.

Sincerely,

Signature on original

Deborah R. Rivkin

Appendix 2

American Diabetes Association

Date: May 6th, 2015

Al Redmer, Jr.
Maryland Insurance Commissioner
Office of the Insurance Commissioner
200 St. Paul Place - Suite 2700
Baltimore, MD 21202

RE: Redetermination of the Benchmark Plan for Essential Health Benefits

Dear Commissioner Redmer:

As you know, Maryland is required to re-determine its benchmark plan for the 2017 plan year Essential Health Benefit (EHB) definition. Each state must choose from one of ten insurance plans that can be used to establish the definition, three of which are federal employee plans. The other options consist of the state's three largest small group plans, three largest state employee plans, and the state's largest commercial HMO plan. The Association would like to better understand the plan options and how these plans meet the needs of people with diabetes therefore **I am requesting the explanation of benefits documents for the seven state-based plans.** The Association would then like to recommend which one of the plans provides the most adequate coverage for people with diabetes based on current standards of care .

Going into this process the Association would urge you to choose a plan where access is affordable and includes adequate coverage. It is critically important to people with, and at risk for, diabetes because foregoing or scaling back care because of access constraints can result in poor health outcomes and increased health care costs.

The Association believes essential benefits for the management, prevention, and care of diabetes should include:

- Diabetes screening for individuals at high risk,
- Services as determined by a treating health care provider;
- Prescriptions;
- Durable medical equipment, including blood glucose testing equipment and supplies and insulin pumps and associated supplies;
- Services related to pregnancy, including screening for diabetes, monitoring and treatment for women with preexisting diabetes and gestational diabetes, and postnatal screening;
- A yearly dilated eye exam by an eye-care professional with appropriate follow-up care as medically needed;
- Podiatric services;
- Diabetes education, including diabetes outpatient self-management training services; and
- Medical nutrition therapy services.

Thank you for your consideration of the critical health care needs of people with diabetes, and our request for the referenced plan documents. Please let me know if you need any additional information.

Sincerely,

Abe Saffer
Southeast State Advocacy Director
American Diabetes Association
Email: asaffer@diabetes.org
Phone: 202-450-8068

Appendix 3

American Speech-Language-Hearing Association



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted via email to Nick.Cavey@maryland.gov

May 11, 2015

Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: 2017 Benchmark Health Plan

Dear Mr. Cavey:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA has carefully reviewed the habilitation benefits of the three largest health plans identified by the Maryland Insurance Administration (MIA) and offers the following comments for consideration.

As you know, the Department of Health and Human Services (HHS) adopted a uniform definition of habilitation that states can use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices— Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Beginning in 2017, qualified health plans will be required to not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. This will ensure that visit limits for habilitative services are not combined with and are separate from rehabilitative services. ASHA supports this policy and further requests that benchmark plans should offer separate visit limits for each of the therapies (i.e., speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. For instance, a benchmark plan that only allows 30 combined visits/member/calendar year for rehabilitative or habilitative services is not adequate coverage. It is not uncommon for an enrollee to require up to 20 visits in a 6-week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.

ASHA has been actively engaged in working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities

and fully supports the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Habilitation services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include hearing aids, augmentative and alternative communication devices, such as speech-generating devices, which aid in hearing and speech, and other assistive technologies and supplies.

Augmentative and alternative communication (ACC) devices are specialized devices that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices. Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.

Before the adoption of the recently finalized federal definition for habilitation services and devices, the state of Maryland passed legislation requiring health plans to provide habilitation services to children with congenital, genetic, or early acquired disorders under the age of 19. Maryland also covers unlimited medically necessary visit limits for habilitation services for children under the age of 19. For members age 19 and above, the legislation requires 30 visits per condition per contract year for each therapy (i.e., physical therapy, speech therapy, and occupational therapy). This is in parity with rehabilitation coverage. In addition, hearing aid coverage only applies to children up to the age of 18 and covers one hearing aid per each hearing impaired ear every 36 months.

In keeping with the newly adopted federal habilitation definition, ASHA requests that MIA change their hearing aid coverage to no longer be limited by age. In the 2016 Notice of Benefit and Payment Parameters final rule, HHS clarified that limiting hearing aids by age is a potentially discriminatory benefit design. We applaud the state of Maryland for not implementing visit limits for medically necessary habilitation services to children under the age of 19 and urge MIA to maintain this requirement.

ASHA further recommends that MIA consider allowing visit limits of habilitation services for members aged 19 and above be in parity with coverage and visit limits for children under the age of 19. We recognize that habilitation services for members aged 19 and above are in parity with rehabilitation coverage, but we do not believe that coverage should be arbitrarily reduced because the patient turns 19. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered medically necessary as long as:

- separate and distinct goals are documented in the treatment plans of physicians, nurses and therapists providing concurrent services;
- the specific services are non-overlapping; and
- each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines.

ASHA would like to mention that HHS clarified in the most recent regulation that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states *do not* defray the cost. This clarification allows states to address coverage gaps in their state. For example, Maryland could expand coverage for hearing aids beyond the age of 18 and provide unlimited medically necessary coverage for habilitation services beyond the age of 19 through a state mandate. The enhanced benefits to existing coverage would then become a part of the essential health benefit as a state mandated benefit and the selected benchmark plan would be required to cover these services.

ASHA appreciates the opportunity to provide comments on this important topic. Please contact Susan Adams, JD, ASHA's director of state legislative and regulatory advocacy, at 301-296-5665 or by e-mail at sadams@asha.org or Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or by e-mail at dgrooms@asha.org, if you require additional information or clarification.

Sincerely,

Signature on original

Judith Page, PhD, CCC-SLP
2015 ASHA President

Appendix 4
Public Policy Partners

May 13, 2015

Commissioner Al Redmer, Jr.
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Commissioner Redmer:

Thank you for the opportunity to submit recommendations on Maryland's selection of its benchmark plan for 2017 to the Maryland Insurance Administration (MIA). We have reviewed the three potential benchmark plans, and we have found that their benefit structure for habilitative services is identical. Therefore, we are not recommending a specific plan to be used as benchmark.

However, we are recommending several actions related to the new federal rule (see attached rule) on habilitative services and devices in the Essential Health Benefits package (EHB). With the exception of one provision, the new rule should be implemented in the 2016 plan year.

Recommendation 1

For the 2016 plan year, carriers should incorporate the new uniform federal definition of habilitative services and devices into their plans, as follows: "services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." This definition, under CFR §156.115(a)(5)(i), will clarify coverage in two key areas:

- Under Health Insurance § 15-835, Maryland's habilitative services mandate for children is limited to a child with a "congenital or genetic birth defect." With the new uniform federal definition, all children up to age of 19-years will be eligible for habilitative services. There will no longer be the qualifier that the child has a "congenital or genetic birth defect."
- "Devices" will be included under the definition of habilitative services. This is an important clarification.

Recommendation 2

In CFR §156.115(a)(5)(iii), the federal rule prohibits carriers from imposing combined limits on habilitative and rehabilitative services and devices in plan year 2017. While we did not see any evidence of combined limits in the three benchmark plans options, we understand that this is an

operational issue, rather than an issue in the benefits structure. In the attached federal rule on page 226, CMS acknowledged the public comment that carriers “do not have operational capacity to differentiate between habilitative services and rehabilitative services and devices based on enrollee diagnosis or whether the enrollee is seeking to maintain or achieve function.” CMS’ response states that the rule is not going into effect until 2017 “to provide issuers with the opportunity to resolve operational issues with their claims systems.”

The Workgroup on Access to Habilitative Services Benefits, facilitated by the MIA, acknowledged this same operational issue in distinguishing between habilitative and rehabilitative services. In its final report in October 2013, the Workgroup recommended that “carriers should distinguish between rehabilitative and habilitative services in their claims systems.”

Given the Workgroup’s recommendation and the final federal rule, we recommend that the MIA follow-up with carriers on their progress in operationalizing the new federal rule. We would appreciate if the MIA could share a summary of their findings with the Workgroup, as it would demonstrate how the Workgroup’s recommendation has been implemented.

Recommendation 3

The new federal rule, under CFR §156.115(a)(6), clarifies that pediatric habilitative coverage is required for “enrollees until at least the end of the month in which the enrollee turns 19 year of age.” The Department of Health and Human Services in its final comments stated that it encouraged plans to provide coverage until the end of plan year under which an enrollee turns 19 years of age.

In the plan documents that we have reviewed, carriers generally specify that habilitative coverage will be provided up to age 19 as opposed to the end of the month in which the enrollee turned 19. Carriers should operationalize this new federal rule by the 2016 plan year.

Recommendation 4

While the MIA can incorporate all of our recommendations into the EHB in 2017 by supplementing the benchmark plan selection, this action will not address the need to implement the new uniform federal rule and the “end-of-the-month” provision in the 2016 plan year. Therefore, our final recommendation is that the MIA issue a bulletin regarding the need to adopt these provisions in the 2016 plan year. We would request that the bulletin also direct the carriers to ensure that they update all benefits information to consumers.

Conclusion

Thank you for your consideration of our comments. If you have any question or need any follow-up information, please contact Robyn Elliott at (443) 926-3443 or relliott@policypartners.net. Ms. Elliott is a public policy and governmental affairs consultant to the Maryland Occupational Therapy Association. She will coordinate communications amongst the signatories to this letter.

Maryland Occupational Therapy Association
Maryland Developmental Disabilities Council
The Arc Maryland
The Parents' Place of Maryland
Pathfinders for Autism

2. Essential Health Benefits Package

a. State selection of benchmark (§156.100)

We proposed to amend paragraph (c) of §156.100 to delete the language regarding the default base-benchmark plan in the U.S. Territories of Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands. The change reflects HHS's determination, described in more detail in section III.A.1.b of this final rule, that certain provisions of the PHS Act enacted in title I of the Affordable Care Act that apply to health insurance issuers are appropriately governed by the definition of "State" set forth in that title. Therefore, the rules regarding EHB (section 2707 of the PHS Act) do not apply to health insurance issuers in the U.S. Territories. We also proposed to make a technical change to this section by replacing "defined in §156.100 of this section" with "described in this section." We note that this has no effect on Medicaid and CHIP programs and that Alternative Benefit Plans will still have to comply with the essential health benefit requirements.

We did not receive any comments regarding this proposal. We are finalizing the provisions as proposed.

b. Provision of EHB (§156.115)

(1) Habilitative Services

One of the 10 categories of benefits that must, under section 1302(b)(1)(G) of the Act, be included under the Secretary's definition of EHB is rehabilitative and habilitative services and devices. If a benchmark plan does not include habilitative services, §156.110(c)(6) of the current EHB regulations requires the issuer to cover habilitative services as specified by the State under §156.110(f) or, if the State does not specify, then the issuer must cover habilitative services in the manner specified in §156.115(a)(5). Section 156.115(a)(5) states that a health plan may

provide habilitative coverage by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services or otherwise determine which services are covered and report the determination to HHS. In some instances, those options have not resulted in comprehensive coverage for habilitative services. Therefore, we proposed amending §156.115(a)(5) to establish a uniform definition of habilitative services that may be used by States and issuers. In addition, we proposed to remove §156.110(c)(6) because that provision gives issuers the option to determine the scope of habilitative services.

We believe that adopting a uniform definition of habilitative services would minimize the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Defining habilitative services clarifies the difference between habilitative and rehabilitative services. Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

We proposed adopting the definition from the Glossary of Health Coverage and Medical Terms:⁴⁵ health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

We did not propose any changes to §156.110(f), which allows States to determine services included in the habilitative services and devices category if the base-benchmark plan

⁴⁵ <http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf>

does not include coverage. Several States have made such a determination following benchmark selection for the 2014 plan year, and we wish to continue to defer to States on this matter as long as the State definition complies with EHB policies, including non-discrimination. If the State does not supplement missing habilitative services or does not supplement the services in an EHB-compliant manner, issuers should cover habilitative services and devices as defined in §156.115(a)(5)(i).

We also proposed to revise current §156.115(a)(5)(ii) to provide that plans required to provide EHB cannot impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. Since the statutory category includes both rehabilitative and habilitative services and devices, we interpret the statute to require coverage of each. Therefore, issuers that previously excluded habilitative services, but subsequently added them, would be required under our proposal to impose separate limits on each service rather than retaining the rehabilitative services visit limit and having habilitative services count toward the same visit limit. Because we proposed to establish a uniform definition of habilitative services in new §156.115(a)(5)(i), we also proposed to delete §156.110(c)(6), which would remove the option for issuers to determine the scope of the habilitative services. In §156.110 we proposed to make a technical change to amend the list structure of paragraph (c) by replacing the “and” in (c)(5) with a period and adding an “and” at the end of (c)(4).

We are finalizing our policy as proposed, adopting the definition of habilitative services from the Uniform Glossary in its entirety, to be effective beginning with the 2016 plan year and requiring separate limits on habilitative and rehabilitative services beginning with the 2017 plan year. We are codifying this final policy in revised §156.115(a)(5) and removing §156.110(c)(6).

Comment: Several commenters requested more State flexibility, even in cases where the benchmark plan includes habilitative services; they sought assurance that a Federal definition will not supersede a State law, and that State-required benefits that could be considered habilitative services would be treated as EHB.

Response: States are required to supplement the benchmark plan if the base benchmark plan does not include coverage of habilitative services as defined in this final rule. We are codifying the definition of habilitative services as a minimum for States to use when determining whether plans cover habilitative services. State laws regarding habilitative services are not pre-empted so long as they do not prevent the application of the Federal definition. State laws enacted in order to comply with §156.110(f) are not considered benefits in addition to the EHB; such laws ensure compliance with §156.110(a) which requires coverage of all EHB categories. Therefore, there is no obligation to defray the cost of such State-required benefits.

Comment: Several commenters objected to imposing separate limits on rehabilitative and habilitative services and devices, claiming issuers do not have operational capacity to differentiate between habilitative and rehabilitative services and devices based on enrollee diagnosis or whether the enrollee is seeking to maintain or achieve function.

Response: We are finalizing the requirement to ensure coverage of each with separate limits, but the requirement will not become effective until 2017. This delay is intended to provide issuers with the opportunity to resolve operational issues with their claims systems.

Comment: Several commenters asked that “devices” be included in the definition of habilitative services.

Response: We originally omitted devices because the term is already included in the statutory description of this category of EHB. In response to comments, however, we have

added “devices” to our regulatory definition. We remind issuers that the statute requires coverage of devices for both rehabilitative and habilitative services.

Comment: Several commenters requested that we require issuers to have an exceptions process similar to the process required by OPM for multi-State plans, in case a patient needs treatment that exceeds the visit limits allowed by the plan.

Response: Enrollees wishing to appeal an adverse benefit determination, including denial of habilitative services, should follow the process established in §147.136, which implements section 2719 of the PHS Act for internal claims and appeals and external review processes.

Comment: Commenters offered many suggestions for specific services and devices, such as orthotics and prosthetics, which they stated should be required to be covered as habilitative services and devices by all issuers.

Response: We are not codifying such a list at this time, as we continue to allow States to maintain their traditional role in defining the scope of insurance benefits, but we encourage issuers to cover additional services and devices beyond those covered by the benchmark plan.

(2) Pediatric Services

In the preamble of the EHB Rule, we stated that pediatric services should be provided until at least age 19 (78 FR 12843). States, issuers, and stakeholders requested clarification on this standard. To provide this clarification, we proposed amending §156.115(a) to add paragraph (6), specifying that EHB coverage for pediatric services should continue until the end of the plan year in which the enrollee turns 19 years of age. This was proposed as a minimum requirement.

41. Section 156.115 is amended by revising paragraphs (a)(5)(i) and (ii) and adding paragraphs (a)(5)(iii) and (a)(6) to read as follows:

§156.115 Provision of EHB.

(a) * * *

(5) With respect to habilitative services and devices –

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;

(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.

(6) For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

* * * * *

42. Section 156.120 is added to read as follows:

§156.120 Collection of data to define essential health benefits.

(a) Definitions. The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at §144.103 of this

Appendix 5

Delta Dental Of Pennsylvania

May 14, 2015

Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
nick.cavey@maryland.gov
SENT VIA E-MAIL

RE: Plan Year 2017 Benchmark Plan Discussion

Dear Mr. Cavey:

On behalf of Delta Dental of Maryland, which provides dental benefits to more than 400,000 enrollees in the State of Maryland, I am pleased to have the opportunity to submit comments on the proposed benchmark for Plan Year 2017.

Currently, the plans for the small group and individual market offered through the Maryland Health Connection utilize CHIP benefits as the benchmark for pediatric dental essential health benefits. The three largest small group plans that are being evaluated for 2017 – CareFirst BlueChoice HMO HSA/HRA, CareFirst BlueChoice HMO Referral, and United Health Insurance Company PPO Plan - are all very similar to the benefits as currently structured. However, the two CareFirst plans are the closest to what we currently offer. The UnitedHealthcare plan appears to be comprehensive for pediatric dental; however, the plan documents do not go into enough detail, particularly on limitations and frequencies, for us to assess whether it aligns with the CHIP benefits.

Therefore, should the United Health Insurance Company PPO plan be chosen as the PY 2017 benchmark plan, we would respectfully request that the pediatric dental benefits be described in more detail so that we may draft our pediatric EHB benefits accordingly. And, whichever plan is chosen, we would like to request that the state provide the detailed benefit information (including procedure codes and frequency limitations) of the dental benefits. This will help with developing a plan that is “substantially equal” to the benchmark.

Sincerely,

Signature on original

Jeff Album
Vice President, Public and Government Affairs

Appendix 6

Maryland Women's Coalition for Health Care Reform



Maryland Insurance Administration
2017 Essential Health Benefit Selection
14 May 2015

The **Maryland Women's Coalition for Health Care Reform**, and the 30 organizations cited below, are pleased to submit comments to the Maryland Insurance Administration (MIA) on the selection of the 2017 Essential Health Benefit Benchmark Plan (EHB). The Coalition is an alliance of more than 1,800 individuals and 100 organizations, whose mission is to advance health equity through access to high-quality, comprehensive and affordable health care for all Marylanders. In that capacity, the Coalition has been particularly active in advancing the voices and interests of consumers in health care reform since passage of the Affordable Care Act (ACA). This included our participation in the decision-making process for the EHB that serves as Maryland's current benchmark. That benchmark plan was selected through an open and inclusive process that allowed time for a comprehensive analysis of the alternatives and resulted in a plan with optimal benefits across all categories.

We understand that the timeframe for the selection process this time is far more limited and, therefore, particularly appreciate your consideration of our recommendations. These are based upon a review of the three possible benchmark plans and related federal guidance. In preparing these we:

- Worked together to prepare a comprehensive document that reflects the priorities of the consumer and community provider organizations that are signatories to this document.
- Understand that behavioral health and habilitative services advocates are submitting more detailed comments in those areas, given the need to provide greater policy detail;
- Included recommendations regarding the implementation of the EHB to promote greater transparency for consumers. We understand that the MIA will likely not have time to consider these recommendations before the selection of the benchmark plan, but we would appreciate ongoing dialogue about the issues.

Recommendation 1: We believe that the BlueChoice HMO HSA/HRA Plan or the BlueChoice HMO Referral Plan best address the needs of consumers. It is, therefore, our preferred option. However, we would note the issues raised in the comments of the University of Maryland Drug Policy Clinic and those in recommendation four below. These will need to be addressed with the final plan selection.

The overriding reason for this recommendation is that the **BlueChoice plans have a higher level of specificity** in their benefit structures. The EHB should identify with maximum specificity the services to be included in each benefit category based upon the HHS requirements (EHB data rule - 77 Fed. Reg. 140, July 20, 2012) that there be

a significant level of specificity in the identification (and approval of) the EHB option chosen by the State.

This is particularly important because consumers require both transparency and specificity in making well-informed decisions about selecting a health insurance plan and health plans require benchmark specificity in order to appropriately design plans to meet the benchmark requirements. The BlueChoice plans have a higher level of specificity in their benefits design than does the United Plan. For example, the BlueChoice plans include:

- Indication that allergy testing, allergy treatment, and allergy shots are covered, while the United Plan only specifies coverage for shots. The United Plan may cover allergy testing and treatment, but it is not clear from its benefit design;
- Delineation of covered infertility services to include counseling, testing, artificial insemination, and intrauterine insemination. The United Plan does not directly address whether counseling, testing, and artificial insemination are covered. While the United Plan may very well cover these services, it is again not clear in the plan documents; and
- Description of emergency room services as including coverage of facility fees, professional fees, and follow-up care after emergency surgery. The United Plan does not specify coverage information for facility vs professional charges, and it is silent on coverage for follow-up service. This information would be useful to the consumer and should be clearly stated.
- A more complete listing of preventive services. However, it includes no mention of adolescent depression and alcohol misuse screening and counseling. This would need to be addressed in the benefit design [to conform to all A and B USPTF designated services](#)

Recommendation 2: The MIA should address the need to incorporate non-discrimination provisions in the benefits design of EHB:

It is critical that the benefit design of the EHB to reflect the federal anti-discrimination requirements. 45 C.F.R. § 156.125(a) and (b) state that an issuer cannot aim to provide the essential health benefits as defined in Section 1302 of the Affordable Care Act if its benefit design—or the implementation of its benefit design— discriminates on the basis of an individual’s sexual orientation, gender identity, sex, race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

We recommend the MIA take the following steps to ensure the plan design of the EHB does not discriminate:

- The MIA should ensure that the EHB includes an anti-discrimination provision, consistent with federal law. We would note that the BlueChoice Plans include a specific provision in their plan documents, while the United Plan does not;

- The MIA should incorporate *HB 838/SB 416 – Health Insurance –Coverage for Infertility Services*. This legislation, passed by both chambers of the 2015 General Assembly, ensures that same-sex couples have access to coverage of infertility services; and
- The MIA should take steps to reverse the current exclusion of certain services related to gender identity. In particular we would note that all three plans include exclusions relating to “treatment leading to or in connection with transexualism, or sex changes or modification including but not limited to surgery.”
- It is difficult to determine potential discrimination issues in the drug benefit without the formulary. Therefore, we recommend that, as the MIA reviews each plan's current formularies, it ensures that any discriminatory issues are addressed for future plans.

Recommendation 3: The MIA should incorporate the new federal definition of habilitative services into the EHB.

We recommend that the MIA specifically incorporate the new federal definition of habilitative services into the EHB for the 2017 plan year. The definition specifically requires that plans:

Cover health care services and devices that help a person keep, learn or improve skills and functioning for daily living (habilitative services.) Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Incorporation of this definition will ensure that all enrollees have access to medically necessary habilitative services and devices. We also support that letter submitted by the Maryland Occupational Therapy Association and disabilities advocates which provides a more detailed review on how the new federal rule should be implemented in Maryland.

Recommendation 4: The MIA should ensure that the EHB does not include outdated references to the scope of practice of health care practitioners.

Our health care system has evolved to incorporate the practices of a wide-range of health care practitioners. Where plans restrict coverage in plan documents to specific types of practitioners, it is important to ensure that those restrictions are not based on out-dated scope of practice. We are happy to work with the MIA and the carriers to ensure that plans are not implementing outdated scope of practice restrictions. In addition, we want to specifically ensure that the language of the EHB does not reference the following restrictions contained in the BlueChoice plans:

- In the definitions section, the BlueChoice plans define “Primary Care Provider” or PCP as a “Primary Care Physician.” This language does not reflect the current practice of including nurse practitioners and nurse midwives in the definition of PCP;

- In the description of Nurse Midwife Services, the BlueChoice Plans specify that nurse midwives must have collaborative agreements with physicians. This is an outdated provision. Maryland law and the Maryland Board of Nursing have not required this for over 5 years; and
- Language in the BlueChoice Plans regarding the providers who may be reimbursed for outpatient and intensive outpatient mental health and substance use disorder services should specifically include substance use disorder treatment programs. Substance use disorder treatment services are provided in large part by certified treatment programs, through certified practitioners as well as licensed practitioners. The BlueChoice plan's limitation on reimbursement for services provided by licensed individual practitioners excludes the core group of substance use treatment providers in Maryland and severely restricts access to care. The United plan has addressed this important issue by allowing for outpatient services to be provided in either a provider's office or an "alternate facility," which is defined to include an outpatient facility that is permitted by law to provide mental health or substance use disorder services.

Recommendation 5: The MIA should continue to collaborate with consumer advocates beyond the selection of the benchmark plan to ensure that consumers are receiving the full benefits of the EHB provisions in the ACA.

We recognize that the MIA has a short period of time in which to select the benchmark plan. Therefore, our intention is to continue a dialogue with the MIA with respect to the following after the benchmark plan selection process:

- **Transparency:** We want to support the MIA's commitment to ensure that consumers have access to meaningful information about benefits. We are concerned about confusion and lack of clarity for consumers where information provided by carriers in Summary and Benefits Coverage (SBC) documents is inconsistent with other plan documents. We are also concerned that carriers differ in how and what is disclosed to consumers regarding their processes for determining medical necessity. Consumers require a clear definition in order to make informed decisions about their plan selection and care; and
- **Accountability:** We want to work with the MIA to ensure that the appropriate processes are in place so that plans are accountable for complying with federal and State law regarding benefits structure, including the requirements of the Mental Health and Addiction Equity Act and the family planning provisions of the Affordable Care Act.

CONCLUSION

Thank you for your consideration of our recommendations. Please let us know if we can provide further information to assist the MIA in the selection of the 2017 benchmark plan.

Submitted by: Leni Preston, Chair - leni@mdchcr.org

Supporting Organizations

Advocates for Children and Youth
American College of Nurse Midwives - Maryland Affairs
Equality Maryland
Drug Policy Clinic, University of Maryland Carey Law School
HealthCare Access Maryland
Maryland Addiction Directors Council
Maryland Center on Economic Policy
Maryland Citizens' Health Initiative
Maryland Disability Law Center
Maryland Nurses Association
Mental Health Association of Maryland
Montgomery County Department of Health and Human Services
National Alliance on Mental Illness -Maryland and
 NAMI Anne Arundel County
 NAMI Carroll County
 NAMI Cecil County
 NAMI Frederick County
 NAMI Harford County
 NAMI Howard County
 NAMI Lower Shore
 NAMI Metropolitan Baltimore
 NAMI Montgomery County
 NAMI Prince George's County
 NAMI Southern Maryland
 NAMI Washington County
National Association of Social Workers
Planned Parenthood of Maryland
Primary Care Coalition of Montgomery County
Progressive Cheverly
Unitarian Universalist Legislative Ministry of Maryland
Women's Law Center of Maryland

Appendix 7

**Drug Policy and Public Health Strategies Clinic of the University of Maryland
Carey School of Law**

**Selection of the 2017 Essential Health Benefit Benchmark Plan
Comments to the Maryland Insurance Administration
May 14, 2015**

The Drug Policy and Public Health Strategies Clinic of the University of Maryland Carey School of Law and the nine (9) undersigned organizations appreciate the opportunity to submit comments to the Maryland Insurance Administration on the selection of the 2017 Essential Health Benefit Benchmark Plan (EHB Benchmark Plan). The mission of the Drug Policy Clinic is to expand access to comprehensive treatment for persons with substance use and mental health disorders and to fight discrimination against individuals based on their history of substance use problems. The Drug Policy Clinic has advocated for robust enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in both the public and private insurance markets so that Maryland's citizens may receive non-discriminatory coverage of and access to substance use and mental health treatment. The selection of the 2017 EHB Benchmark Plan provides an opportunity for the State to implement the right framework to achieve equitable coverage of substance use and mental health benefits in individual and small employer health plans, as required by the Affordable Care Act (ACA) and the Parity Act.

The Clinic is pleased that the three EHB benchmark options are non-grandfathered plans that have incorporated, to a significant degree, the mental health and substance use disorder benefit that was selected in 2012 for the State's EHB benchmark plan. The current benchmark plan adopted the mental health/substance use disorder benefit from the 2012 Federal Employee Health Benefit Program's Government Employees Health Association (GEHA) plan in order to comply with the Parity Act.¹ The GEHA plan provides a full continuum of outpatient and inpatient services and, with the exception of one feature that restricts the eligible providers of outpatient services, (see Section B below), satisfies the Parity Act's standard for the scope of benefits that must be offered in an EHB-based plan.

Although the current set of benefits is the correct starting point for the State's 2017 EHB Benchmark Plan, neither the CareFirst BlueChoice plans (HMO HSA/HRA 1500 and HMO Referral) nor the United Healthcare plan fully satisfies the Parity Act's standards. The BlueChoice benefit includes a limitation on the types of providers that are eligible for reimbursement for outpatient services, in violation of the Parity Act, and does not explicitly identify two preventive services related to behavioral health that must be included in that benefit. The United HealthCare plan, while addressing the provider restriction, excludes coverage of several substance use disorder services. The United HealthCare plan also delegates all coverage decisions to a Mental Health/Substance Use Disorder Designee, whose standards are not identified in the plan documents. We urge the MIA to adopt a parity compliant benchmark

¹ Under the ACA, the ten essential health benefits include mental health and substance use disorder services and, significantly, the definition of "providing essential health benefits" means that the mental health/substance use disorder benefit must comply with the Parity Act. 45 C.F.R. § 156.115(a)(3). To satisfy federal law, a health plan's financial requirements, quantitative treatment limitations and non-quantitative treatment limitations for mental health and substance use disorder benefits can be no more restrictive than the standards applied to medical and surgical benefits.

benefit by either addressing the restriction on outpatient providers, as set out in the BlueChoice plan benefits, or correcting the substance use disorder benefit exclusions in the United HealthCare plan.

A. Mental Health and Substance Use Disorder Benefits

1. Scope of Treatment Services

The current substance use and mental health benefit, adopted from the GEHA benefit and set out in MIA Bulletin 13-01, provides a full continuum of outpatient care; intermediate levels of care, such as partial hospitalization and residential treatment; and inpatient care; as well as diagnostic services, detoxification and medication management. The BlueChoice plans offer this set of benefits (HMO Referral and HMO HSA-HRA 1500 at B-30) and provide a level of specificity that helps consumers understand the full scope of covered services. For example, the explicit identification of methadone maintenance treatment in the schedule of benefits (HMO Referral at C-7 and HMO HSA-HRA 1500 at C-8) informs consumers of this important outpatient benefit.

In contrast, the United HealthCare plan does not cover two important benefits that are clearly required under the State's benchmark benefit: ambulatory detoxification services and partial hospitalization that is provided in a substance use treatment facility. (Certificate of Coverage at 17). The United HealthCare plan covers "detoxification services in a Hospital or Related Institution." (Certificate of Coverage at 12). Hospital care requires an inpatient stay, as does care in a "related institution," which is defined as a facility that "admits or retains an individual for overnight care." (Certificate of Coverage at 68). This limitation conflicts with the substance use disorder benefit in MIA Bulletin 13-01, § 5(a)(i)(E), which does not limit the setting in which detoxification services may be provided. This limitation on the setting of care would also constitute a violation of the final Parity Act regulations, which identify a restriction on "facility type" as a non-quantitative treatment limitation. 45 C.F.R. §146.136(c)(4)(ii)(H). A health plan cannot restrict the setting in which substance use detoxification services are provided unless the plan imposes a comparable restriction on the delivery of medical services. No such limitation is found in the United HealthCare benefit.

The United HealthCare plan's coverage for partial hospitalization is limited to services in a "Hospital, psychiatric day-care treatment center, or community mental health facility." (Certificate of Coverage at 66). This restriction conflicts with the partial hospitalization benefit in MIA Bulletin 13-01, which imposes no restriction on the setting in which such service can be provided (*see* § 5(c) "services such as partial hospitalization or intensive day treatment"). Like the detoxification benefit, this restriction would violate the Parity Act. **These limitations should have been identified in the MIA's plan certification process and must be corrected immediately so that consumers receive the benefits they are entitled to receive.**

Finally, the scope of benefits under the United HealthCare plan appears to be fluid because the plan delegates all coverage decisions to its Mental Health/Substance Use Disorder Designee. (Certificate of Coverage at 17). Although the plan sets out the covered benefits, the Certificate of Coverage states that "[t]he Mental Health/Substance Use Disorder Designee determines coverage decisions for all levels of care." (Certificate of Coverage at 17). While this provision could be

interpreted to reference the Designee's authority to determine whether a listed service is medically necessary for a specific patient, it also suggests that other limitations may exist on the covered services which have not been identified in the plan documents. The Designee's standards are critical to a determination of whether the United HealthCare plans comply with the Parity Act, and should be included in the plan documents and reviewed by the MIA prior to plan certification.

2. Preventive Services

Both the BlueChoice and the United HealthCare plans state that preventive services designated as A or B services by the United States Preventive Services Task Force are covered under the Benchmark Plan. This benefit complies with the ACA, however, the Blue Choice plan fails to identify two critical behavioral health services – screening for depression in adolescents and alcohol misuse screening and counseling – despite the fact that the plan lists, with great specificity, a range of preventive services that it does cover. These two evidence-based preventive services should be identified in the benefit to the extent the BlueChoice Plan documents set out any other preventive service.

Based on a review of the scope of services in the three benchmark options, the Blue Choice plans are better aligned with the existing benchmark benefit and are more consistent with the Parity Act standards.

B. Providers of Outpatient and Intensive Outpatient Treatment Services

The State's current EHB Benchmark Plan provides for the delivery of outpatient and intensive outpatient services by *licensed practitioners*, and, by its terms, excludes the delivery of outpatient services by state-certified/licensed substance use disorder treatment programs and certified substance use disorder practitioners acting within the scope of their practice. *See* MIA Bulletin 13-01.² This restriction, incorporated from the GEHA benefit, effectively excludes from carrier networks the core set of substance use disorder treatment providers that deliver outpatient and intensive outpatient services in the State. This benefit limitation fails to reflect Maryland's "program-based" substance use disorder treatment system³ and the delivery of care through both

² The benefit explicitly covers outpatient and intensive outpatient services provided "by *licensed* professional mental health and substance use practitioners when acting within the *scope of their license*, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists." MIA Bulletin 13-01, § 5(a) at 3. This licensed practitioner limitation does not apply to partial hospitalization or residential treatment services as those services are covered when provided by the "residential treatment center" or the "partial hospitalization or intensive day treatment program." MIA Bulletin 13-01, § 5(b) and (c) at 4.

³ A significant portion of substance use treatment is provided by community-based substance use programs that are certified or, under new standards, licensed by the State. MD. CODE ANN. HEALTH-GEN. §§ 8-403 and 8-404. Methadone treatment services, for example, can only be provided by a program, pursuant to 42 C.F.R. Part 8 and COMAR § 10.47.02.11. Although the State is beginning to implement a new program licensure process, it will not alter the State's program-based treatment system or the mix of practitioners who deliver substance use treatment services.

licensed and certified providers. This restriction limits access to substance use treatment services, and it violates the Parity Act, as clarified in the final regulations.⁴ In April 2013, the Drug Policy Clinic raised this significant issue with the MIA and asked that it clarify that state-certified substance use treatment programs would be eligible for reimbursement for outpatient services. Although the MIA declined to amend the standard, it issued Bulletin 13-19 to clarify that carriers may contract “with State-certified outpatient and intensive outpatient treatment programs to assist the carrier in delivering a full continuum of medically necessary and appropriate substance use disorder services.” (MIA Bulletin 13-19).

The Parity Act compels a different result now. The final Parity Act regulations make clear that the existing limitation on the professionals who may provide outpatient and intensive outpatient services constitutes a restriction based on “provider specialty” that is a non-quantitative treatment limitation. 45 C.F.R. § 146.136(c)(4)(ii)(H). The EHB Benchmark Plan may not restrict the delivery of outpatient substance use disorder services by excluding eligible providers that meet state qualifications to deliver outpatient treatment unless it imposes the same restrictions on outpatient medical/surgical services.

The BlueChoice plans retain this limitation (HMO HSA-HRA 1500 and Referral at B-30). That benchmark benefit may not be adopted unless the restrictive standard is removed. On the other hand, the United HealthCare plan appropriately adjusts for the State’s program-based delivery system, consistent with the Parity Act regulations. (Certificate of Coverage at 17). The United HealthCare plan provides that outpatient mental health and substance use disorder services “include those received on outpatient basis [sic] in a provider’s office or an Alternate Facility.” The plan defines “alternate facility” as a non-hospital “health care facility that provides...services on an outpatient basis, as permitted by law [including] Mental Health Services or Substance Use Disorder Services.” (Certificate of Coverage at 60). Accordingly, as long as a substance use treatment program is authorized by law to provide services, it is eligible under the United HealthCare plan to deliver and be reimbursed for outpatient substance use services.

We recommend that MIA revise the BlueChoice outpatient mental health and substance use disorder benefit by inserting the “alternate facility” standard provided in the United HealthCare plan. Failure to do so will allow for a Parity Act violation to be baked into the benchmark benefit.

C. Conclusion

The adoption of the 2017 EHB Benchmark Plan is only the first step in ensuring that EHB-based health plans comply with the Parity Act. A wide range of plan design features – defined as non-quantitative treatment limitations – are implicated in the provision of essential health benefits for mental health and substance use disorders. Yet very few of those standards are identified in the consumer’s insurance contract or plan documents, providing no basis on which to evaluate

⁴ The final Parity Act regulations, which were promulgated in November 2013 after the selection of the 2012 EHB Benchmark Plan, offer additional guidance on the standards that constitute a non-quantitative treatment limitation. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (Nov. 13, 2013).

whether a plan offers essential health benefits or to file a complaint when mental health or substance use disorder services are denied.

The Clinic reiterates the serious concern it has raised with both the MIA and Health Benefit Exchange since 2014: carriers do not submit sufficient information in their rate and form filings or other submissions to allow for a complete review of plan compliance with the Parity Act prior to plan certification. In addition, a review of the benchmark plan options reveals that the MIA has not identified violations of the Parity Act, even when the non-compliant provisions are set out in the plan documents. More individuals than ever have private insurance coverage as a result of the ACA's individual mandate and expanded insurance market. They should not be denied life-saving care by carriers that continue to implement discriminatory insurance standards. The Clinic urges the State to require carriers to submit additional information relevant to a parity compliance review and to pursue a far more robust review of plans to ensure that consumers receive the mental health and substance use disorder benefits that they are paying for and are entitled to receive.

Thank you for considering our views.

Ellen Weber
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410-706-0590

Baltimore City Substance Abuse Directorate
Community Behavioral Health Association of Maryland
Maryland Addictions Directors Council (MADC)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland-Recovery Organization Connecting Communities (M-ROCC)
Maryland Society for Addiction Medicine (MDSAM)
Maryland Women's Coalition for Health Care Reform
Mental Health Association of Maryland (MHAMD)
National Council on Alcoholism and Drug Dependence-Maryland (NCADD-Maryland)

CC: Carolyn Quattrocki, Executive Director, Maryland Health Benefit Exchange

Appendix 8

Habilitation Benefits Coalition



May 14, 2015

Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: 2017 Benchmark Health Plan

Dear Mr. Cavey:

Thank you for the opportunity to comment on Maryland's 2017 benchmark benefits plan under the Affordable Care Act. The undersigned members of the HAB Coalition would like to focus on comments on the definitional and coverage issues involving the benefit category of "rehabilitative and habilitative services and devices."

The HAB Coalition is a group of national nonprofit consumer and clinical organizations focused on securing appropriate access to, and coverage of, habilitation benefits within the category known as "rehabilitative and habilitative services and devices" in the EHB package under the Patient Protection and Affordable Care Act (ACA), Section 1302.

We request that the Maryland Insurance Administration (MIA), in establishing Maryland's 2017 benchmark health plan, explicitly adopt a habilitative and rehabilitative benefit that complies with the newly-issued federal regulations for this benefit category under the Affordable Care Act. By recognizing these regulations, Maryland will be clarifying coverage of this benefit category consistent with the Centers for Medicare and Medicaid Services' (CMS') February 27 final rule, titled *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 – Final Rule* ([The Rule](#)).

Specifically, we request that MIA:

- **Adopt the Rule's definition of habilitation services and devices¹ as the floor in determining coverage for habilitation services and devices for individual and small**

¹ See §156.115(a)(5), page 10871 of [The Rule](#): "Habilitation services and devices— Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

employer health insurance plans beginning in 2016. The HAB Coalition believes that adopting a uniform definition minimizes the variability in benefits and uncertainty involving the habilitation benefit. While we support Maryland's explicit adoption of the uniform federal definition, we stress that this definition is a floor for coverage and that the services and devices covered by the habilitation benefit should not be limited to the therapies enumerated in the federal regulation as *examples* of covered benefits.

- **Not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services.** This will ensure separate and distinct habilitative and rehabilitative services limits, if any, are applied to these different sets of services based on the needs of individuals receiving them.
- **Do not impose combined limits on habilitative and rehabilitative services and devices.** If states choose to impose limits on these benefits, the federal regulations require separate limits for rehabilitation and habilitation benefits after January 1, 2017.
- **For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.**
- **Does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.** These nondiscrimination protections are included in the ACA statute at Section 1302 and form the basis for plan benefit design that is equitable and meets the needs of diverse populations. We recommend that MIA further consider these nondiscrimination issues by examining the document found at:
http://www.insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

We appreciate the opportunity to provide comments on this important topic. Should you have further questions regarding this information, please contact Peter Thomas or Steven Postal, HAB Coalition staff, by emailing them at Peter.Thomas@ppsv.com or Steven.Postal@ppsv.com, respectively, or by calling 202-466-6550.

Sincerely,

American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Heart Association / American Stroke Association
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Physical Therapy Association

American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of University Centers on Disabilities
Autism Speaks
ACCSES
Brain Injury Association of America
Children's Defense Fund
Christopher & Dana Reeve Foundation
Easter Seals
Family Voices
Hearing Loss Association of America
Lakeshore Foundation
Legal Action Center
Lutheran Services of America
Disability Network
March of Dimes
National Association for the Advancement of Orthotics and Prosthetics
National Association of Councils on Developmental Disabilities
National Association of County Behavioral Health and Development Disability Directors
National Association of Social Workers
National Down Syndrome Society
Paralyzed Veterans of America
TASH
United Cerebral Palsy
United Spinal Association

Appendix 9

Maryland American Speech-Language-Hearing Association State Advocate for Reimbursement

May 14, 2015

Nick Cavey
Assistant Director of Government and External Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: 2017 Benchmark Health Plan

Dear Mr. Cavey:

The Maryland Speech-Language Hearing Association (MSHA) supports the American Speech-Language Hearing Association (ASHA) position on consideration of the 2017 Benchmark Health Plan. I am a former MSHA President, former Director of Public Policy, current ASHA State Advocate for Reimbursement (STAR) and ASHA's MD representative Advisory Council (AC). MSHA represents both consumers and SLP and Audiology professionals. We provide information to the General Assembly, MSDE and DHMH.

ASHA has carefully reviewed the habilitation benefits of the three largest health plans identified by the Maryland Insurance Administration (MIA) and offers the following comments for consideration.

“As you know, the Department of Health and Human Services (HHS) adopted a uniform definition of habilitation that States can use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices – Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. “

“Beginning in 2017, qualified health plans will be required to not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. This will ensure that visit limits for habilitative services are not combined with and are separate from rehabilitative services. ASHA supports this policy and further requests that benchmark plans should offer separate visit limits for each of the therapies (e.g., speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. For instance, a benchmark plan that only allows 30 combined visits/member/calendar year for rehabilitative or habilitative services is not adequate coverage. It is not uncommon for an enrollee to require up to 20 visits in a 6 week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.”

“ASHA has been actively engaged in working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities and fully support the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Habilitation services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include hearing aids, augmentative and alternative communication devices, such as speech generating devices, which aid in hearing and speech, and other assistive technologies and supplies. Augmentative and alternative communication (AAC) devices are specialized devices that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices. Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.”

“Before the adoption of the recently finalized federal definition for habilitation services and devices, the state of Maryland passed legislation requiring health plans to provide habilitation services to children with congenital, genetic, or early acquired disorders under the age of 19. Maryland also covers unlimited medically necessary visit limits for habilitation services for children under the age of 19. For members age 19 and above, 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy). This is in parity with rehabilitation coverage. In addition, hearing aid coverage only applies to children up to the age of 18 and covers one hearing aid per each hearing impaired ear every 36 months.”

“In keeping with the newly adopted federal habilitation definition, ASHA requests that MIA change their hearing aid coverage to no longer be limited by age. In the 2016 Notice of Benefit and Payment Parameters final rule, HHS clarified that limiting hearing aids by age is a potentially discriminatory benefit design. We applaud the state of Maryland for not implementing visit limits for medically necessary habilitation services to children under the age of 19 and urge MIA to maintain this requirement. ASHA further recommends that MIA consider allowing visit limits of habilitation services for members aged 19 and above be in parity with coverage and visit limits for children under the age of 19. We recognize that habilitation services for members aged 19 and above are in parity with rehabilitation coverage, but we do not believe that coverage should be arbitrarily reduced because the patient turns 19. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered medically necessary as long as:

- Separate and distinct goals are documented in the treatment plans of physicians, nurses and therapists providing concurrent services;
- The specific services are non-overlapping; and
- Each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines “

ASHA also states, “ HHS clarified in the most recent regulation that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states **do not** defray the cost. This clarification allows states to address coverage gaps in their state. For example, Maryland could expand coverage for hearing aids beyond the age of 18 and provide unlimited medically necessary coverage for habilitation services beyond the age of 19 through a state mandate. The enhanced benefits to existing coverage would then become a part of the essential health benefit as a state mandated benefit and the selected benchmark plan would be required to cover these services.”

MSHA appreciates having this opportunity to provide comment. MSHA’s Director of Public Policy is Nancy Brandenburger. She can be contacted at slpkentisland@gmail.com. The MSHA Administrator, Lisa Oriolo can be reached at office@mdslha.org or by phone 410.239.7770.

Sincerely,

Gloria Petit-Clair, M.Ed SLP
MD ASHA STAR
MD ASHA SLP Advisory Council
Past President, MSHA

DRAFT

Appendix 10

Maryland Speech-Language-Hearing Association



Nick Cavey -MDInsurance- <nick.cavey@maryland.gov>

2017 Benchmark Health Plan

1 message

Angela Mezzomo <mezzomoang@aol.com>

Thu, May 14, 2015 at 11:00 PM

To: Nick.Cavey@maryland.gov

Dear Mr. Cavey:

The Maryland Speech-Language-Hearing Association (MSHA) is a professional association comprised of over **700 speech/language pathologists and audiologists**. MSHA advocates for people of all ages who have speech, language, swallowing and/or hearing disabilities. MSHA has carefully reviewed the habilitation benefits of the three largest health plans identified by the Maryland Insurance Administration (MIA) and, in agreement with the American Speech-Language Hearing Association, offers the following comments for consideration.

As you know, the Department of Health and Human Services (HHS) adopted a uniform definition of habilitation that States can use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices – Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Beginning in 2017, qualified health plans will be required to not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. This will ensure that visit limits for habilitative services are not combined with and are separate from rehabilitative services. MSHA supports this policy and further requests that benchmark plans should offer separate visit limits for each of the therapies (e.g., speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. For instance, a benchmark plan that only allows 30 combined visits/member/calendar year for rehabilitative or habilitative services is not adequate coverage. It is not uncommon for an enrollee to require up to 20 visits in a 6 week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.

MSHA has been actively engaged in working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities and fully support the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Habilitation services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include hearing aids, augmentative and alternative communication devices, such as speech generating devices, which aid in hearing and speech, and other assistive technologies and supplies.

Augmentative and alternative communication (ACC) devices are specialized devices that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices. Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.

Before the adoption of the recently finalized federal definition for habilitation services and devices, the state of Maryland passed legislation requiring health plans to provide habilitation services to children with congenital, genetic, or early acquired disorders under the age of 19. Maryland also covers unlimited medically necessary visit limits for habilitation services for children under the age of 19. For members age 19 and above, 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy). This is in parity with rehabilitation coverage. In addition, hearing aid coverage only applies to children up to the age of 18 and covers one hearing aid per each hearing impaired ear every 36 months.

In keeping with the newly adopted federal habilitation definition, MSHA requests that MIA change their hearing aid coverage to no longer be limited by age. In the 2016 Notice of Benefit and Payment Parameters final rule, HHS clarified that limiting hearing aids by age is a potentially discriminatory benefit design. We applaud the state of Maryland for not implementing visit limits for medically necessary habilitation services to children under the age of 19 and urge MIA to maintain this requirement. MSHA further recommends that MIA consider allowing visit limits of habilitation services for members aged 19 and above be in parity with coverage and visit limits for children under the age of 19. We recognize that habilitation services for members aged 19 and above are in parity with rehabilitation coverage, but we do not believe that coverage should be arbitrarily reduced because the patient turns 19. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered medically necessary as long as:

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- The specific services are non-overlapping; and
- Each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines

MSHA would like to mention that HHS clarified in the most recent regulation that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states *do not* defray the cost. This clarification allows states to address coverage gaps in their state. For example, Maryland could expand coverage for hearing aids beyond the age of 18 and provide unlimited medically necessary coverage for habilitation services beyond the age of 19 through a state mandate. The enhanced benefits to existing coverage would then become a part of the essential health benefit as a state mandated benefit and the selected benchmark plan would be required to cover these services.

Sincerely,

H. Angela Mezzomo PhD, CCC-SLP
2015 MSHA President

