MARTIN O'MALLEY
Governor

ANTHONY G. BROWN
Lt. Governor

BETH SAMMIS, Ph.D.
Acting Commissioner

KAREN STAKEM HORNIG
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
1-800-492-6116 TTY: 1-800-735-2258
www.mdinsurance.state.md.us

BULLETIN 10-23

Date: July 15, 2010

To: Insurers, Nonprofit Health Service Plans and Health Maintenance Organizations ("Carriers")

Re: Contract Amendment Templates for Compliance with Patient Protection and Affordable Care Act

In response to requests from the industry, the Maryland Insurance Administration has developed the attached amendment rider templates to assist carriers in drafting amendments to comply with portions of the Patient Protection and Affordable Care Act ("PPACA") and interim final regulations issued by the Department of Health and Human Service, under 45 CFR Parts 144, 146 and 147.

This is the second bulletin dealing with template text that may be used to bring contracts into compliance with PPACA and the interim final regulations. The first bulletin was Bulletin 10-17, issued June 3, 2010, which dealt with covering adult children to age 26. These amendment templates deal with the issues of lifetime limits, annual limits, rescissions, preventive services, prohibitions on pre-existing condition exclusions and limitations, choice of provider and emergency services. The templates are designed to be used for plan years (for individual contracts, policy years) that begin on or after September 23, 2010.

Finally, these templates were drafted to meet the minimum requirements of Maryland and federal law. If the contract to which a template is attached is more generous to the covered individuals than the template, the templates may not be used to reduce the benefits of the contract.

The amendment rider templates for the group market may be used with both the small group and large group contracts and certificates.

Questions about this bulletin may be directed to the Life/Health Section of the Maryland Insurance Administration at 410-468-2170.

Signature on file with Original

Brenda A. Wilson
Associate Commissioner
Life and Health Section

[COMPANY NAME]
Lifetime Limit and Rescissions: Template for Individual Grandfathered Contracts

The individual contract to which this amendment rider is attached is amended as described below.

Definitions

The following definitions have the following meanings in this amendment rider:

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Policy year" means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the contract is deleted.

The contract is amended to provide that if an individual's coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a policy year that begins on or after September 23, 2010, and coverage will begin on the first day of the policy year that begins on or after September 23, 2010.

Rescissions

Any provision of the contract that describes the right of [*insert company name*] to rescind or void the contract is amended to permit [*insert company name*] to rescind or void the coverage of an individual only if (1) the individual performs an act, practice, or omission that constitutes fraud; or (2) the individual makes an intentional misrepresentation of material fact.

Any provision of the contract that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

This amendment rider shall be effective [*insert effective date of amendment rider*].

_____
Signature of Officer

[COMPANY NAME]
Lifetime Limit, Annual Limit, Pre-Existing Condition Exclusion, and Rescissions: Template for Group Grandfathered Contracts

The group contract or certificate to which this amendment rider is attached is amended as described below.

Definitions

The following definition is added to the group contract and certificate:

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the group contract or certificate is deleted.

The group contract and certificate are amended to provide that if an individual's coverage under the group contract or certificate had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a plan year that begins on or after September 23, 2010, and coverage will begin on the first day of the plan year that begins on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any essential health benefits in the group contract or certificate is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the group contract or certificate.

Rescissions

Any provision of the group contract or certificate that describes the right of [*insert company name*] to rescind or void the contract or to rescind the coverage of an individual under the contract is amended to permit [*insert company name*] to rescind or void the entire group contract or the coverage of an individual only if (1) the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Any provision of the group contract or certificate that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

Prohibition on Pre-Existing Conditions for Children

The following provisions of the group contract or certificate shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the individual is covered under the group contract or certificate; and
(4) Any provision of the group contract or certificate that describes possible denial or rejection of coverage due to underwriting.

This amendment rider shall be effective [*insert effective date of amendment rider*].

_____
Signature of Officer

[COMPANY NAME]

Lifetime Limit, Annual Limit, Pre-Existing Condition Exclusion, Rescissions, Preventive Services, Choice of Provider and Emergency Services Amendment: Template for Individual Non-Grandfathered Contracts

The individual contract to which this amendment rider is attached is amended as described below.

Definitions

The following definitions have the following meanings in this amendment rider:

"Emergency services" means, with respect to an emergency medical condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Non-participating provider" means a health care practitioner or health care facility that has not contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

"Participating provider" means a health care practitioner or health care facility that has contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

"Policy year" means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the contract is deleted.

The contract is amended to provide that if an individual's coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a policy year that begins on or after September 23, 2010, and coverage will begin on the first day of the policy year that begins on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any essential health benefits in the contract is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the contract.

Rescissions

Any provision of the contract that describes the right of [*insert company name*] to rescind or void the contract is amended to permit [*insert company name*] to rescind or void the coverage of an individual only if (1) the individual performs an act, practice, or omission that constitutes fraud; or (2) the individual makes an intentional misrepresentation of material fact.

Any provision of the contract that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

Preventive Services

In addition to any other preventive benefits described in the contract, [*insert company name*] shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits [*for PPO, EPO or HMO plans, insert "for services received from participating providers"*]:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding

breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

[*Drafting note: for individual PPO contracts, insert "For services received from non-participating providers, the preventive service benefits described above shall be covered at 80% of the amount covered for services received from participating providers."*]

[*Insert company name*] shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Prohibition on Pre-Existing Conditions for Children

The following provisions of the contract shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the contract; and
(4) Any provision of the contract that describes possible denial or rejection of coverage due to underwriting.

Choice of Provider [*Drafting note: do not include this provision if the contract does <u>not require</u> the selection of a primary care provider by an individual*]

Any provision of the contract that indicates that an individual is required to designate or provide for the designation of a primary care provider is amended to permit the individual to select any participating primary care provider who is available to accept the individual.

Any provision of the contract that indicates that a primary care provider is required to be designated for a child, is amended to permit the designation of any participating physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider, if the provider is available to accept the child.

Any provision of the contract that requires a woman to receive a referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating

provider who specializes in obstetrics or gynecological care is deleted. The contract is also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care provider includes the ordering of related obstetrical and gynecological items and services that are covered under the contract.

Emergency Services

Any provision of the contract that provides benefits with respect to services in an emergency department of a hospital is amended to provide emergency services:

1. Without the need for any prior authorization determination, even if the emergency services are provided by a non-participating provider;
2. Without regard to whether the health care provider furnishing the emergency services is a participating provider with respect to the services; and
3. If the emergency services are provided by a non-participating provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers.

Cost-Sharing Requirements for Emergency Services

If any copayment amount or coinsurance percentage described in the contract for emergency services is different for a service received from a participating provider than a non-participating provider, the copayment amount and coinsurance percentage for emergency services provided by a non-participating provider is amended to be identical to the copayment amount and coinsurance percentage listed in the contract for emergency services provided by a participating provider.

[*Drafting note: Do not include the following paragraph in a rider to be used with an HMO contract, as amounts to be paid by HMOs to non-participating providers are already set forth in Maryland law and balance billing by non-participating HMO providers is prohibited in Maryland*]

[*Insert company name*] shall pay the greater of the following amounts for emergency services received from non-participating providers:

1. The amount set forth in the contract to which this amendment rider is attached.
2. The amount negotiated with participating providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider. If there is more than one amount negotiated with participating providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.
3. The amount for the emergency service calculated using the same method [*insert company name*] generally used to determine payments for services provided by a non-participating

provider (such as usual, customary and reasonable amount), excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.

4. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.

Any other provision of the contract that describes cost-sharing for services received from non-participating providers, other than copayment amounts or coinsurance responsibilities, continue to apply to emergency services received from non-participating providers. Examples of these cost-sharing requirements include deductibles and out-of-pocket limits. Any out-of-pocket limit described in the contract that generally applies to services received from non-participating providers is applicable to emergency services received from non-participating providers.

This amendment rider shall be effective [*insert effective date of amendment rider*].

_____

Signature of Officer

[COMPANY NAME]

Lifetime Limit, Annual Limit, Pre-Existing Condition Exclusion, Rescissions, Preventive Services, Choice of Provider and Emergency Services Amendment: Template for Group Non-Grandfathered Contracts

The group contract or certificate to which this amendment rider is attached are amended as described below.

Definitions

The following definitions have the following meanings in this amendment rider:

"Emergency services" means, with respect to an emergency medical condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Non-participating provider" means a health care practitioner or health care facility that has not contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

Participating provider means a health care practitioner or health care facility that has contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the group contract or certificate is deleted.

The group contract and certificate are amended to provide that if an individual's coverage under the group contract or certificate had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a plan year that begins on or after September 23, 2010, and coverage will begin on the first day of the plan year that begins on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any essential health benefits in the group contract or certificate is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the group contract or certificate.

Rescissions

Any provision of the group contract or certificate that describes the right of [*insert company name*] to rescind or void the contract or to rescind the coverage of an individual under the contract is amended to permit [*insert company name*] to rescind or void the entire group contract or the coverage of an individual only if (1) the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Any provision of the group contract or certificate that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

Preventive Services

In addition to any other preventive benefits described in the group contract or certificate, [*insert company name*] shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits [*for PPO, EPO or HMO plans, insert "for services received from participating providers"*:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the

current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

[*Drafting note: for individual or large group PPO contracts, insert "For services received from non-participating providers, the preventive service benefits described above shall be covered at 80% of the amount covered for services received from participating providers."*

For small group PPO contracts, insert "For services received from non-participating providers, the preventive service benefits described above shall be subject to the cost-sharing requirements described in the contract for the majority of other services received from non-participating providers, not including the cost-sharing listed for emergency services, mental health services, infertility services, outpatient rehabilitation services, and chiropractic services."]

[*Insert company name*] shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Prohibition on Pre-Existing Conditions for Children

The following provisions of the group contract or certificate shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the group contract or certificate; and
(4) Any provision of the group contract or certificate that describes possible denial or rejection of coverage due to underwriting.

Choice of Provider [*Drafting note: do not include this provision if the contract does <u>not require</u> the selection of a primary care provider by an individual*]

Any provision of the group contract or certificate that indicates that an individual is required to designate or provide for the designation of a primary care provider is amended to permit the individual to select any participating primary care provider who is available to accept the individual.

Any provision of the group contract or certificate that indicates that a primary care provider is required to be designated for a child, is amended to permit the designation of any participating physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider, if the provider is available to accept the child.

Any provision of the group contract or certificate that requires a woman to receive a referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care is deleted. The group contract and certificate are also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care provider includes the ordering of related obstetrical and gynecological items and services that are covered under the group contract or certificate.

Emergency Services

Any provision of the group contract or certificate that provides benefits with respect to services in an emergency department of a hospital is amended to provide emergency services:

1. Without the need for any prior authorization determination, even if the emergency services are provided by a non-participating provider;
2. Without regard to whether the health care provider furnishing the emergency services is a participating provider with respect to the services; and
3. If the emergency services are provided by a non-participating provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers.

Cost-Sharing Requirements for Emergency Services

If any copayment amount or coinsurance percentage described in the group contract or certificate for emergency services is different for a service received from a participating provider than a non-participating provider, the copayment amount and coinsurance percentage for emergency services provided by a non-participating provider is amended to be identical to the copayment amount and coinsurance percentage listed in the group contract or certificate for emergency services provided by a participating provider.

[*Drafting note: Do not include the following paragraph in a rider to be used with an HMO contract or certificate, as amounts to be paid by HMOs to non-participating providers are already set forth in Maryland law and balance billing by non-participating HMO providers is prohibited in Maryland*]

[*Insert company name*] shall pay the greater of the following amounts for emergency services received from non-participating providers:

1. The amount set forth in the group contract or certificate to which this amendment rider is attached.
2. The amount negotiated with participating providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider. If there is more than one amount negotiated with participating providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.
3. The amount for the emergency service calculated using the same method [*insert company name*] generally used to determine payments for services provided by a non-participating provider (such as usual, customary and reasonable amount), excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.
4. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.

Any other provision of the group contract or certificate that describes cost-sharing for services received from non-participating providers, other than copayment amounts or coinsurance responsibilities, continue to apply to emergency services received from non-participating providers. Examples of these cost-sharing requirements include deductibles and out-of-pocket limits. Any out-of-pocket limit described in the group contract or certificate that generally applies to services received from non-participating providers is applicable to emergency services received from non-participating providers.

This amendment rider shall be effective [*insert effective date of amendment rider*].

_____

Signature of Officer