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### BULLETIN 13-01

Date: January 3, 2013

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

Re: Maryland Benchmark Plan and Essential Health Benefits

The purpose of this bulletin is to provide detailed information to carriers regarding the essential health benefits that will be required of non-grandfathered health benefit plans in the individual and small group markets with plan years (policy years for individual health benefit plans) that begin on or after January 1, 2014.

#### *Selection of Benchmark Plan*

In accordance with § 31-116 of the Insurance Article of the Annotated Code of Maryland, the Maryland Health Care Reform Coordinating Council ("MHCRC") selected the health plan with the largest small group enrollment as the Maryland benchmark plan. The chosen benchmark plan contains benefits in addition to the comprehensive standard health plan benefits required by regulations promulgated by the Maryland Health Care Commission (COMAR 31.11.06). It includes wellness benefits, insulin pump benefits, cardiac rehabilitation benefits, extended organ transplant benefits, pulmonary rehabilitation benefits, extended nutritional counseling and medical nutrition therapy benefits, and delivery of benefits through patient centered medical homes.

The chosen benchmark plan was lacking the adult habilitative benefits and the pediatric oral and vision benefits required by 45 C.F.R. § 156.110<sup>1</sup>. Therefore, in accordance with the proposed rule the MHCRC supplemented the benchmark plan with the Maryland Children's Health Insurance Plan dental benefit and the FEP Blue Vision high plan, respectively. The MHCRC has also determined that the adult habilitative benefits will equal the rehabilitative benefits in the benchmark plan.

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<sup>1</sup> The proposed rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* ("proposed rule") See 77 Fed. Reg. 70, 644 (proposed Nov. 26, 2012)(to be codified at 45 C.F.R. pts. 147, 155, 156).

The chosen benchmark plan also needed to be enhanced for mental health and substance use disorder services. The MHCRC determined that the benchmark's mental health/substance use benefit will be the mental health/substance use benefit found in the Government Employees Health Association, Inc. Benefit Plan.

For the individual market, in accordance with the proposed rule (45 C.F.R. § 155.170), the benchmark plan described above will be overlaid with the mandated benefits that applied to health benefit plans in the individual market as of December 31, 2011, and which do not appear in the chosen small group benchmark plan. This means that benefits for in vitro fertilization and hair prosthesis will be included as essential health benefits for the individual market.

#### *Small Group Market Essential Health Benefits*

The following is a description of the essential health benefits that will be required of each non-grandfathered health benefit plan in the small group market with plan years that begin on or after January 1, 2014. Specifically, the essential benefits shall include:

1. Except as specified in item 5 below, the benefits described in Regulations .03, .03-1 and .09 of COMAR 31.11.06.
2. Habilitative services for adults (those 19 and over) that are at least equal to the rehabilitative benefits described in COMAR 31.11.06.03A(15).
3. Pediatric vision benefits for children up to age 19 in accordance with the FEP Blue Vision high plan. The FEP Blue Vision high plan benefits include the following benefits:
  - a. One routine eye examination, including dilation if professionally indicated, each year;
  - b. One pair of prescription eyeglass lenses each year
  - c. One frame each year;
  - d. In lieu of eyeglasses, one pair of contact lenses each year; and
  - e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.
4. Pediatric dental benefits for children up to age 19<sup>2</sup> in accordance with the Maryland Children's Health Insurance Plan dental benefit, which includes benefits for:

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<sup>2</sup> 45 C.F.R. § 155.1065 allows the pediatric dental component of the Essential Health Benefits (EHB) to be offered through a stand-alone dental plan in an Exchange. If stand-alone dental plans are available in the Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits Qualified Health Plans offered in the Exchange to exclude coverage of the pediatric dental component of the EHB.

- a. Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and
  - b. Treatment of all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontic services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.
5. Mental health and substance use benefits in accordance with the Government Employees Health Association, Inc. Benefit Plan, which includes:
- a. Professional services 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.
    - i. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:
      - A. Diagnostic evaluation;
      - B. Crisis intervention and stabilization for acute episodes;
      - C. Medication evaluation and management (pharmacotherapy);
      - D. Treatment and counseling (including individual or group therapy visits);
      - E. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
      - F. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.
    - ii. Electroconvulsive therapy;
    - iii. Inpatient professional fees;
    - iv. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;
    - v. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;
    - vi. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

- b. Inpatient hospital and inpatient residential treatment centers services, which includes:
    - i. Room and board, such as:
      - A. Ward, semiprivate, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract covers only the hospital's average charge for semiprivate accommodations.);
      - B. General nursing care;
      - C. Meals and special diets.
    - ii. Other facility services and supplies--Services provided by a hospital or residential treatment center (RTC).
  - c. Outpatient hospital—Services such as partial hospitalization or intensive day treatment programs.
  - d. Emergency room—Outpatient services and supplies billed by a hospital for emergency room treatment.
  - e. Permissible exclusions for the mental health and substance use benefit:
    - i. Services by pastoral or marital counselors;
    - ii. Therapy for sexual problems;
    - iii. Treatment for learning disabilities and intellectual disabilities;
    - iv. Telephone therapy;
    - v. Travel time to the member's home to conduct therapy;
    - vi. Services rendered or billed by schools, or halfway houses or members of their staffs;
    - vii. Marriage counseling;
    - viii. Services that are not medically necessary.
6. Wellness benefits, which include:
- a. A health risk assessment that is completed by each individual on a voluntary basis; and

- b. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.
7. Insulin pumps--The diabetes treatment, equipment and supplies benefit of COMAR 31.11.06.03A(29) and COMAR 31.11.06.03H is expanded to include insulin pumps.
8. Cardiac rehabilitation benefits for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include:
  - a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and
  - b. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation of 90 visits per therapy, per contract year.
  - c. Exclusions applicable to cardiac rehabilitation—
    - i. Services must be provided at a place of service equipped and approved to provide cardiac rehabilitation.
    - ii. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.
9. Solid organ transplants and other non-solid organ transplant procedures—The organ transplant benefit found in COMAR 31.11.06.03A(20) is expanded to include all medically necessary non-experimental/investigational solid organ transplant and other non-solid organ transplant procedures. Covered services include the cost of hotel lodging and air transportation for the recipient individual and a companion (or the recipient individual and two companions if the recipient individual is under the age of 18 years), to and from the site of the transplant.
10. Pulmonary rehabilitation benefits (one (1) program per lifetime) for individuals who have been diagnosed with significant pulmonary disease. Permissible limitations include:
  - a. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation services;

- b. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.
11. Professional nutritional counseling and medical nutrition therapy—The nutritional services benefit found in COMAR 31.11.06.03A(19) is expanded to include benefits for unlimited medically necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. It also includes unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care physician, to treat a chronic illness or condition.
12. Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:
- a. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;
  - b. Creation and supervision of a care plan;
  - c. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and
  - d. Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.
13. While abortion coverage is a part of the benchmark plan, in accordance with § 1303(b)(1)(A) of the Affordable Care Act, carriers will not be required to cover these services.

With regard to permissible limitations and exclusions, the following apply:

- 1. The contracts may not contain any limitations or exclusions other than those listed in COMAR 31.11.06.06 or listed in items 5, 8 and 10 above with respect to specific required benefits.<sup>3</sup>
- 2. The exclusion for the purchase, examination and fitting of eyeglasses, which is currently found in COMAR 31.11.06.06B(6), is required to be revised to indicate that it does not apply to the pediatric vision benefit.

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<sup>3</sup> Utilization review will be permitted for health benefit plans that are subject to the essential benefits described in this bulletin.

3. The exclusion for services for sterilization or reverse sterilization for a dependent minor, which is currently found in COMAR 31.11.06.06B(13), is required to be revised to indicate that it does not apply to FDA approved sterilization procedures for women with reproductive capacity as this is a required preventive benefit under the Affordable Care Act and COMAR 31.11.06.03-1.
4. The exclusion for accidents occurring while and as a result of chewing, which is currently found in COMAR 31.11.06.06B(28), is required to be revised to indicate that it does not apply to the pediatric dental benefit.
5. The exclusion for organ transplants not otherwise listed in COMAR 31.11.06.03, which currently is found in COMAR 31.11.06.06B(35), is required to be deleted. This exclusion contradicts the additional organ transplant benefit described in item 9 above.
6. The limitation that requires that all mental health and substance use services be provided through the carrier's managed care system is required to be deleted, as it violates the federal Mental Health Parity and Equity Addiction Act.
7. The exclusion for tobacco cessation, which currently appears in COMAR 31.11.06.06B(51), will not be permitted, as it contradicts the tobacco cessation preventive service benefits required by the Affordable Care Act and COMAR 31.11.06.03-1.
8. In accordance with 45 C.F.R. § 147.126, annual dollar limits on specific benefits, such as the \$1400 annual limit on hearing aids, are no longer permitted.

*Individual Market Essential Health Benefits*

The following is a description of the essential health benefits that will be required of each non-grandfathered health benefit plan in the individual market with policy years that begin on or after January 1, 2014. Specifically, the essential benefits shall include:

1. All of the benefits required in the small group market identified above;
2. In vitro fertilization in accordance with § 15-810 of the Insurance Article, except that the \$100,000 maximum lifetime benefit is not permitted by 45 C.F.R. § 147.126; and
3. Hair prosthesis in accordance with § 15-836 of the Insurance Article, except that the \$350 limit is not permitted by 45 C.F.R. § 147.126.

With regard to permissible limitations and exclusions, the same permissible limitations and exclusions that are applicable in the small group market also will be applicable in the individual market, with the following exceptions:

1. The exclusion for in vitro fertilization, which is currently found in COMAR 31.11.06.06B(11), will not be permitted.
2. The exclusion for wigs or cranial prosthesis, which is currently found in COMAR 31.11.06.06B(39), is required to be revised to indicate that it does not apply to hair

prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer.

The above information is based on the assumption that the Secretary of the Department of Health and Human Services approves Maryland's selection of the benchmark plan.

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

*Signature on original*



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Brenda A. Wilson  
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Life and Health