WES MOORE
Governor

ARUNA MILLER
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

TAMMY R. J. LONGAN
Acting Deputy Commissioner

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

BULLETIN 23-5

Date: March 17, 2023

To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations

Re: Maryland Benchmark Plan - Presumptively Discriminatory Plan Designs

---

The purpose of this Bulletin is notify insurers, nonprofit health service plans, and health maintenance organizations ("carriers") that offer non-grandfathered health benefit plans in the individual or small group market in Maryland of required revisions to certain essential health benefits ("EHB") that are included in the current Maryland benchmark plan.

Previously, in Bulletin 15-33, the Maryland Insurance Administration ("MIA") advised carriers that a new benchmark plan was selected that established the EHBs for individual and small employer non-grandfathered health benefit plans. The bulletin also explained that certain benefits and exclusions in the chosen benchmark plan were required to be amended as federal guidance had determined that the benefit or exclusion was considered to be a discriminatory benefit design. This included the hearing aid benefit, the benefit for coverage of artificial insemination and intrauterine insemination procedures, and the exclusion for treatment leading to or in connection with transsexualism, or sex changes or modifications.

On May 6, 2022, the Department of Health and Human Services ("HHS") finalized the *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023* (87 Fed. Reg. 27208). Under the final rule, 45 C.F.R. § 156.125(a) was revised to specify that a non-discriminatory benefit design that provides EHB is one that is clinically-based. The preamble to the final rule at 87 FR 27301-27305 provides examples of health plan designs that HHS would deem to be presumptively discriminatory based on whether the benefit designs were adequately supported by appropriate clinical evidence relevant to each circumstance. These examples include autism spectrum disorder coverage limitations based on age and limitations on foot care coverage based on diagnosis (whether diabetes or another underlying medical condition). HHS concluded that age limits are presumptively discriminatory under § 156.125

when applied to services that are covered as EHB and there is no clinical basis for the age limitation; and that benefit designs that restrict coverage on the basis of a health condition are presumptively discriminatory under § 156.125 when applied to EHB services and there is no clinical basis for the limitation.

Based on this updated guidance, and in consultation with representatives of the Centers for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight, the MIA has determined that certain benefits and exclusions in the Maryland benchmark plan are presumptively discriminatory and must be revised as follows:

1. The EHBs established under the benchmark plan for non-grandfathered small employer and individual health benefit plans include habilitative services for both children and adults, and allow visit limits for adults, but do not allow visit limits for services for children. Under the updated guidance, this practice is presumptively discriminatory and prohibited since there is no clinical basis for the visit limits to be based on age. Visit limits for habilitative services for adults are required to be deleted.

2. In accordance with 45 CFR § 155.170 and §31-116(d)(2) of the Insurance Article, for non-grandfathered individual health benefit plans, the EHBs found in the benchmark plan for the small group market were overlaid with the mandated benefits that applied to health benefit plans in the individual market as of December 31, 2011. Specifically, one of these EHBs is the mandated benefit required by § 15-836 of the Insurance Article, which requires coverage for one hair prosthesis when prescribed by the attending oncologist when hair loss is caused by chemotherapy or radiation treatment for cancer. Under the updated federal guidance, this benefit is presumptively discriminatory because it restricts coverage on the basis of a health condition and there is no clinical basis for the limitation.

   To comply with 45 CFR §156.125, the hair prosthesis benefit for non-grandfathered individual health benefit plans must be revised to provide coverage for one hair prosthesis when prescribed by a provider. A hair prosthesis shall be considered medically necessary when prescribed by the attending oncologist for an individual whose hair loss results from chemotherapy or radiation treatment for cancer. When a hair prosthesis is prescribed by a provider for an individual whose hair loss results from a condition other than treatment for cancer, a determination not to provide coverage by a private review agent, carrier, or health care provider acting on behalf of a carrier shall constitute an adverse decision under Title 15, Subtitle 10A, of the Insurance Article if such determination is based on a finding that the prescribed hair prosthesis is not medically necessary appropriate, or efficient.

3. For non-grandfathered individual health benefit plans, the permissible exclusion in the benchmark plan for wigs or cranial prosthesis is required to be revised to indicate that it does not apply to hair prostheses in the situations described in item 2. above.

Questions about this Bulletin may be directed to the Life & Health Division of the Maryland Insurance Administration at 410-468-2170.

KATHLEEN A. BIRRANE
Commissioner

By:

Signature on Original

_____

David Cooney
Associate Commissioner
Life and Health