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January 15, 2014

The Honorable Thomas M. Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

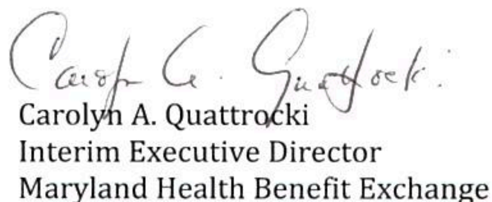
The Honorable Peter A. Hammen
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Dear Chairmen Middleton and Hammen:

Attached please find the Maryland Health Benefit Exchange's annual report required by the Maryland Health Benefit Exchange Act of 2011. As you may recall, the statute requires the Exchange to submit the report "in a standardized format required by the Secretary of the Department of Health and Human Services (HHS)." Md. Code Ann., Ins. § 31-119(b)(3) The federal regulations governing the report are not yet final, and the initial state-based marketplace annual reports will not be due until April, 2015. In the meantime, though, we agreed back in December to submit to the committees an interim report which would provide general information about Maryland Health Connection and the first half of open enrollment. When HHS establishes the required format for these reports, the Exchange will prepare future reports accordingly.

As always, if you would like any additional information, please do not hesitate to contact me.

Very truly yours,



Carolyn A. Quattrocki
Interim Executive Director
Maryland Health Benefit Exchange

cc: Joshua M. Sharfstein, M.D., Chairman
Members of the Board

Maryland Health Benefit Exchange (MHBE)

# Annual Report 2013

1-15-2014

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## INTRODUCTION:

The Maryland Health Benefit Exchange Act of 2011 requires the Maryland Health Benefit Exchange (MHBE) to forward to the Secretary, the Governor and the General Assembly an annual report on the activities, expenditures, and receipts of the Exchange in a standardized format required by the Secretary of the Department of Health and Human Services (HHS). Md. Code Ann., Ins. § 31-119(d) This requirement is based on provisions of the Patient Protection and Affordable Care Act (PPACA) which have yet to be fully implemented. However, in order to provide the General Assembly with an update on the first half of open enrollment, this report will provide information on health plan participation, consumer enrollment, financial integrity, and fraud waste and abuse prevention efforts. Future reports will utilize HHS's annual reporting requirements upon their final adoption.

## 1. Plan Participation:

Maryland Health Connection has had strong insurer participation in its first year, with eight carriers offering qualified health and stand-alone dental plans in the individual marketplace.

Specifically, the following carriers offered qualified health plans on Maryland Health Connection:

- CareFirst (CareFirst Blue Choice, CareFirst of Maryland Inc., and Group Hospitalization and Medical Services Inc.),
- Evergreen (Evergreen Health Cooperative),
- Kaiser Permanente (Kaiser Foundation Health Plan) and
- UnitedHealthcare (All Savers Insurance Co).

The following carriers offered qualified stand-alone dental plans on Maryland Health Connection:

- Delta Dental (Alpha Dental Programs and Delta Dental of PA),
- DentaQuest (DentaQuest Mid-Atlantic),
- Dominion Dental (Dominion Dental Services) and
- United Concordia (United Concordia Life and Health).

To offer a qualified health plan on Maryland Health Connection, a carrier must obtain prior approval of rates and benefits from the Maryland Insurance Administration. (Md. Code Ann., Ins. § 31-115(b)(2)) Under PPACA and State law, the only factors by which an individual can be rated are household size, the age of those covered (3:1 maximum ratio for adults 19-64), tobacco use (1:1.5), and rating region (Baltimore, Eastern and Southern Maryland, Washington DC Metropolitan, and Western Maryland). (Md. Code Ann., Ins. § 15-1205) Rates for products approved for offer on Maryland Health Connection can be seen at http://www.mdinsurance.state.md.us/sa/consumer/md-health-connection-plans.html, as well as in the attached Exhibits. (Exhibit A) In addition, financial assistance in the form of Advanced Premium Tax Credits has the additional impact of significantly lowering the cost of premiums, making health insurance more affordable for many of the State's uninsured. (Exhibit B)

The comprehensive nature of the benchmark plan chosen by the State also enhances the value of the qualified health plans offered on Maryland Health Connection. Specifically, all qualified health plans must offer essential health benefits covering ten required categories: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care[1]. In December 2012, the Maryland Health Care Reform Coordinating Council ("HCRCC") selected the State's small group health plan as the State's benchmark to ensure that all ten essential health benefits were covered. (Exhibit C) To protect further against any potential gaps, the HCRCC supplemented the benchmark plan with the Maryland Children's Health Insurance Plan dental

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[1] Pediatric dental is not required to be embedded in a medical plan as long as a stand-alone dental plan is offered on Maryland Health Connection.

benefit and FEP blue Vision high plan, substituted a more comprehensive federal employee (GEHA) behavioral health benefit, and added an adult component to the existing child habilitative services benefit. The result of HCRCC's work is that Marylanders now have access to a comprehensive benefit package. (Exhibit D)

This comprehensive essential health benefit package required of all plans notwithstanding, variations in cost-sharing and plan design offer consumers a wide variety of options in choosing a plan that best suits their needs. Carriers can set the value of their products at four different actuarial levels - platinum (90%), gold (80%), silver (70%), bronze (60%) – and may also offer catastrophic plans (available only to those under 30 and covering mainly preventive services). As such, carriers participating on Maryland Health Connection have offered a variety of choices:

**Medical Plans By Carriers**

| Parent Company | Licensed Entity | # of Plans | Metal Levels |
|---|---|---|---|
| CareFirst | • CareFirst Blue Choice | 11 | 1 platinum, 3 gold, 3 silver, 3 bronze, 1 catastrophic |
| | • CareFirst of Maryland Inc. | 2 | 1 platinum, 1 bronze |
| | • Group Hospitalization and Medical Services Inc. | 2 | 1 platinum, 1 bronze |
| CareFirst (Multi-State Plan) | • CareFirst of Maryland Inc. | 2 | 1 gold, 1 silver |
| | • Group Hospitalization and Medical Services Inc. | 2 | 1 gold, 1 silver |
| Evergreen | • Evergreen Health Cooperative | 9 | 4 gold, 4 silver, 1 bronze |
| Kaiser Permanente | • Kaiser Foundation Health Plan | 9 | 2 gold, 3 silver, 3 bronze, 1 catastrophic |
| UnitedHealth care | • All Savers Insurance Co. | 8 | 1 gold, 4 silver, 2 bronze, 1 catastrophic |
| | Total: | 45 | |

## 2. Customer Choice/Enrollment:

The State is a little more than halfway through the six month open enrollment period which ends March 31, 2014. As of January 4, 2014, enrollments in qualified health plans increased to a total of 20,358 individuals, and thousands more Marylanders have been found eligible for a Medicaid program through Maryland Health Connection. As of January 6, 2014, approximately 26,500 of these individuals were enrolled in Medicaid, and MHBE expects many more to be enrolled in the coming weeks, with coverage retroactive to January 1. MHBE has been issuing weekly reports on enrollment and other metrics since the beginning of open enrollment, and these reports are attached in Exhibit E.

## 3. Financial Integrity:

MHBE has and will continue to use the financial guidelines prescribed by the Maryland Comptroller to ensure its financial integrity. In areas where MHBE has been exempted from various State procedures that affect the finances and/or procurement of the agency, the MHBE Board of Trustees has approved policies to which MHBE staff must adhere. Procurement policies are listed in the *Resolution Adopting Procurement Policies and Procedures* http://marylandhbe.com/wp-content/uploads/2012/10/Permanent_Procurement_Policies1.pdf. (Exhibit F) MHBE also complies with all audits conducted by the Department of Legislative Services Office of Legislative Auditors, as well as by the Center for Consumer Information and Insurance Oversight, the regulatory arm of the Center for Medicare and Medicaid Services that oversees State–based health exchanges.

The Maryland State Comptroller is responsible for collecting the assessment generated by "...the 2% premium tax on each authorized insurance company, surplus lines broker, or unauthorized insurance company that sells, or an individual who independently procures, any type of insurance coverage upon a risk that is located in the State." (Department of Legislative Services Fiscal and Policy Note – HB228, Maryland Health Progress Act of 2013). At this point, it is too early to determine definitively the increased revenue generated by the implementation of Maryland's state-based health exchange, as open enrollment continues until March 31, 2014.

MHBE's enabling legislation created a special, non-lapsing fund which would consist of user fees or other assessments collected by the Exchange, all revenue deposited into the fund derived from a 2% tax on premiums, all revenue deposited into the fund from the Maryland Health Insurance Plan Fund, income from investments made on behalf of the fund, interest on deposits or investment of money in the fund, money collected by the Board as a result of a legal or other actions, money donated to the fund, money awarded to the fund through grants, and any other source accepted on behalf of the fund. Under the Maryland Health Progress Act of 2013, any funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year

shall revert to the State General Fund. No revenue has yet to be deposited into the MHBE Fund. Initial deposits should occur in FY15.

As a supplement to this report, MHBE will forward a separate financial summary of its budget and grant funding.

## 4. Fraud, Waste and Abuse Detection:

The Maryland Health Benefit Exchange Act of 2012 requires MHBE to establish a Fraud, Waste, and Abuse Detection and Prevention Program designed to ensure MHBE's compliance with federal and State laws for the detection and prevention of fraud, waste, and abuse. Md. Code Ann., Ins. § 31-119(b)(1) In June, MHBE submitted its Fraud, Waste, and Abuse Prevention and Detection Program to the Senate Finance Committee and the House Health Government Operations Committee to allow the committees 60 days for review and comment before establishing the program. MHBE received no comments and is in the process of establishing the program.

## Conclusion:

The wide variety of affordable plans offered on Maryland Health Connection is a critical component of its long term success. With the financial assistance also available through Maryland Health Connection, many more Marylanders can now afford to select among different affordable options that meet their unique needs. We have made significant progress addressing technical problems with Maryland Health Connection, and we will continue working to address outstanding IT issues. Enrollment is expected to continue to increase until open enrollment closes on March 31, 2014.

## Exhibits:

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

**Insurer and Filing Information**

| Company Name | CareFirst BlueChoice, Inc. | Company NAIC# | 96202 |
|---|---|---|---|
| Product Name | BlueChoice Plus; BlueChoice HMO; HealthyBlue | SERFF # | CFBC-128965637; CFBC-128965510; CFBC-128965654 |
| Type of Insurance | Medical | Rate Filing Date | April 1, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 28137MD037 28137MD038 28137MD039 28137MD040 | Rate Effective Date | January 1, 2014 |

**Requested and Approved Average Premium Rates**

| Average Premium Rate Requested by the Company | $217.67 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | 10,530 |
|---|---|---|---|
| Average Premium Rate Approved by the MIA | $193.42 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 11.3% |
| Difference Between Requested and Approved Average Premium Rates* | -11% | | |

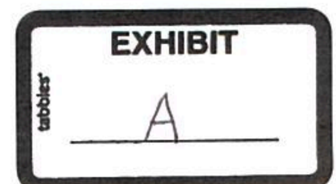
**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

**Rate Review Standards and Considerations**

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits





or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to this objection. Those changes resulted in a 0.9% reduction in the proposed average premium rate.

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.1% decrease);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease);
- corrected its age normalization calculation (resulting in a 3.1% increase);
- removed tobacco rating factors (resulting in a 3.6% increase);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase); and
- decreased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase).

The total effect of these changes was a 0.3% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 10.2% decrease to the average premium rate.

The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 11% from the average premium rate as proposed in the Company's filing.

**Final Determination**

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

**MARYLAND INSURANCE ADMINISTRATION**
**2014 HEALTH INSURANCE PREMIUM RATE DECISION**
**NON-GRANDFATHERED PLAN**

## Insurance Company and Filing Information

| | | | |
|---|---|---|---|
| Company Name | CareFirst of Maryland, Inc. | Company NAIC# | 47058 |
| Product Name | BluePreferred PPO | SERFF # | CFBC-128965513 |
| Type of Insurance | Medical | Rate Filing Date | April 1, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 45532MD025<br>45532MD026 | Rate Effective Date | January 1, 2014 |

## Requested and Approved Average Premium Rate

| | | | |
|---|---|---|---|
| Average Premium Rate Requested by the Company | $252.31 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | 11,164 |
| Average Premium Rate Approved by the MIA | $222.56 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 15.4% |
| Difference Between Requested and Approved Average Premium Rates* | -12% | | |

**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

## Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in a 4.7% reduction to the proposed average premium rate, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

**Final Determination**

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

**Insurance Company and Filing Information**

| Company Name | Group Hospitalization and Medical | Company NAIC# | 47058 |
|---|---|---|---|
| Product Name | BluePreferred Multistate PPO | SERFF # | CFBC-128966538 |
| Type of Insurance | Medical | Rate Filing Date | April 1, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 45532MD017<br>45532MD019 | Rate Effective Date | January 1, 2014 |

**Requested and Approved Average Premium Rate**

| Average Premium Rate Requested by the Company | $252.31 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | 11,164 |
|---|---|---|---|
| Average Premium Rate Approved by the MIA | $222.56 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 12.1% |
| Difference Between Requested and Approved Average Premium Rates* | -12% | | |

**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

**Rate Review Standards and Considerations**

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in an average premium rate reduction of 4.7%, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

The company removed elective abortion coverage from the multistate product. The result was a 0.5% rate decrease. That rate decrease is not reflected in the tabulated figures because those are based on Essential Health Benefits, which do not include abortion coverage.

**Final Determination**

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits

**MARYLAND INSURANCE ADMINISTRATION**
**2014 HEALTH INSURANCE PREMIUM RATE DECISION**
**NON-GRANDFATHERED PLAN**

## Insurance Company and Filing Information

| | | | |
|---|---|---|---|
| Company Name | CareFirst of Maryland, Inc. | Company NAIC# | 47058 |
| Product Name | BluePreferred Multistate PPO | SERFF # | CFBC-128966539 |
| Type of Insurance | Medical | Rate Filing Date | April 1, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 45532MD023<br>45532MD029 | Rate Effective Date | January 1, 2014 |

## Requested and Approved Average Premium Rate

| | | | |
|---|---|---|---|
| Average Premium Rate Requested by the Company | $252.31 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | 11,164 |
| Average Premium Rate Approved by the MIA | $222.56 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 15.4% |
| Difference Between Requested and Approved Average Premium Rates* | -12% | | |

**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

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## Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in a 4.7% reduction to the proposed average premium rate, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

The company removed elective abortion coverage from the multistate product. The result was a 0.5% rate decrease. That rate decrease is not reflected in the tabulated figures because those are based on Essential Health Benefits, which do not include abortion coverage.

**Final Determination**

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

**MARYLAND INSURANCE ADMINISTRATION**
**2014 HEALTH INSURANCE PREMIUM RATE DECISION**
**NON-GRANDFATHERED PLAN**

**Insurance Company and Filing Information**

| | | | |
|---|---|---|---|
| Company Name | Evergreen Health Cooperative, Inc. | Company NAIC# | None (HIOS Issuer ID 72564) |
| Product Name | Evergreen Health Individual | SERFF # | EGHC-128964708 |
| Market Segment | Individual | Rate Filing Date | March 30, 2013 |
| Type of Insurance | Medical | Rate Decision Date | July 26, 2013 |
| Product ID # | 72564MD0010001<br>72564MD0010003<br>72564MD0030001<br>72564MD0030003<br>72564MD0010002<br>72564MD0010007<br>72564MD0030002<br>72564MD0030007<br>72564MD0030011 | Rate Effective Date | January 1, 2014 |

**Requested and Approved Average Premium Rates**

| | | | |
|---|---|---|---|
| Average Premium Rate Requested by the Company | $351.49 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | Company has no current policyholders in the Maryland individual market |
| Average Premium Rate Approved by the MIA | $307.89 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 0 |
| Difference Between Requested and Approved Average Premium Rates* | -12% | | |

***The difference is rounded to the nearest full percentage point.***
*****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

**Rate Review Standards and Considerations**

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

In response to the MIA's inquiries during the course of the rate review process, the Company proposed a modified premium rate that reduced the originally proposed premium rates as follows:

- Reinsurance Recovery Assumptions – The Company assumed an unreasonably low reinsurance reimbursement payment for reinsurance claims of 80% of the amount between $60,000 and $250,000. The Company's original figure of $8.00 PMPM was only 2% of claims cost. The Company agreed to increase the reinsurance payment to $28.00 PMPM. This modification results in an 8% decrease in Evergreen's average premium rate.
- Assumptions about the Anticipated Health of the Population - The Company modified its projections regarding the anticipated health of enrollees in its individual market products in 2014, which resulted in a reduction of approximately 3.4% in its average premium rate.
- Adjustment to Risk Adjustment, Profit, and Administrative Expense – Changes related to the expected claims cost described above resulted in a change to the risk adjustment, profit, and administrative expense amounts resulting in a 1% decrease to Evergreen's average premium rate.

The Company's approved average premium rate, as modified during the rate review process, is approximately 12% less than the average premium rate as filed.

**Final Determination**

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

**MARYLAND INSURANCE ADMINISTRATION**
**2014 HEALTH INSURANCE PREMIUM RATE DECISION**
**NON-GRANDFATHERED PLANS**

## Insurance Company and Filing Information

| Company Name | Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. | Company NAIC# | 95639 |
|---|---|---|---|
| Product Name | Individual Health Organization – Health Maintenance (HMO) | SERFF # | KPMA-128967538 |
| Type of Insurance | Medical | Rate Filing Date | April 1, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 90296MD001001<br>90296MD001002 | Rate Effective Date | January 1, 2014 |

## Requested and Approved Average Premium Rates

| Average Premium Rate Requested by the Company | $331.09 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | 3,787 |
|---|---|---|---|
| Average Premium Rate Approved by the MIA | $327.31 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | 4.3% |
| Difference Between Requested and Approved Average Premium Rates* | -1% | | |

**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

## Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the

individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Generally, the data provided by the Company and the Company's assumptions supported the originally proposed premium rates.

However, during the course of the rate review process, the MIA determined that the Company had used an unreasonably high 10% pent-up demand factor for currently uninsured individuals who are projected to become Kaiser Foundation individual market members in 2014. The MIA required that the pent-up demand factor be reduced to 5%.

The effect of this rate modification is an approximately 1% reduction to the average premium rate as filed by the Company.

**Final Determination**

Pursuant to § 11-603)c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

**MARYLAND INSURANCE ADMINISTRATION**
**2014 HEALTH INSURANCE PREMIUM RATE DECISION**
**NON-GRANDFATHERED PLAN**

## Insurer and Filing Information

| | | | |
|---|---|---|---|
| Company Name | All Savers Insurance Company | Company NAIC# | 82406 |
| Product Name | Individual MHBE PPO Plan | SERFF # | AMMS-128944485 |
| Type of Insurance | Medical | Rate Filing Date | March 28, 2013 |
| Market Segment | Individual | Rate Decision Date | July 26, 2013 |
| Product ID # | 36677MD002<br>36677MD003<br>36677MD004<br>36677MD005<br>36677MD006<br>36677MD007<br>36677MD008<br>36677MD009 | Rate Effective Date | January 1, 2014 |

## Requested and Approved Average Premium Rates

| | | | |
|---|---|---|---|
| Requested Average Premium Rate | $478.48 | Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company | Company has no current policyholders in the Maryland individual market |
| Approved Average Premium Rate | $323.20 | Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate** | N/A |
| Difference Between Requested and Approved Average Premium Rates* | -33% | | |

**The difference is rounded to the nearest full percentage point.*
***This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.*

***These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.***

**Rate Review Standards and Considerations**

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

**Modifications to Requested Rates and Reasons for Those Modifications**

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

In response to MIA inquiries during the course of the rate review process, All Savers reduced its requested average premium rates by 16.5%. This 16.5% was achieved by a combination of the following three factors:

- Reducing the "morbidity factor" used to account for the anticipated health of enrollees in its individual market products in 2014 from 25% to 12.5%;
- Increasing the loss ratio target, net of reinsurance, from 74.3% to 78.0%; and
- Reducing administrative expenses from 12.5% to 6.5%.

All Savers' original rate filing included an Exchange fee of 3.5% of premium. When questioned about this, All Savers eliminated this Exchange fee and replaced it with a 3.5% commission rate.

The Commissioner required further modifications of certain assumptions used by the Company in developing it proposed rates as follows.

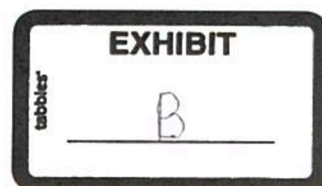
- All Savers' initial individual rate filing, as filed on March 28, 2013, was based upon Maryland small group experience as filed on April 5, 2013 under SERFF UHLC-128948506. On May 8, 2013, All Savers reduced its rates in that small group filing by 15.6%. Therefore, All Savers' requested average premium rate for the individual market was reduced by an additional 15.6%.
- All Savers used an overall annual trend figure of 9% in developing its rates. This figure included a 1% "margin". Trend is inherently an estimate and inclusion of a "margin" in trend is not appropriate. Therefore, the 1% margin in trend for 2 years was removed. This reduced the average premium rate by an additional 2%.
- The Commissioner required a further reduction in the morbidity factor from 12.5% to 10%.

The Company further modified its proposed rates accordingly.

The Company's approved average premium rate, as modified during the rate review process, is approximately 33% less than the average premium rate as filed.

**Final Determination**
Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

# Maryland Health Connection
# Sample Rate Scenarios
# October 2013



# Frequently Asked Questions

### How were these rates calculated?

The rates charged by health insurance companies for each plan are developed by the health insurance company and approved by the Maryland Insurance Administration. By law, insurance companies can develop rates based only on the age, geographic location, tobacco status and family composition of a consumer. They cannot consider the health status of an individual when determining insurance prices. The rates used in these scenarios are examples of the lowest cost plans that would be available.

### How are the tax credits calculated?

The Affordable Care Act states that individuals, based on their household size and income, are only allowed to pay a certain percentage of their income towards their health insurance premium. To calculate the tax credit a household may receive, we take the second lowest-cost silver plan available to that household and subtract the amount the household is allowed to pay for health insurance, and that is the amount of the tax credit.

### What is a bronze, silver, gold or platinum plan?

These four classifications, also called metal levels, represent how much of your health care the health insurance company pays for. With a bronze plan, the health insurance company pays about 60% of your health care costs, which means that you pay about 40% in deductibles, copayments and other out-of-pocket expenses when you use health services. With a silver plan, the health insurance company pays about 70%. A gold plan is 80% and a platinum plan is 90%. Bronze plans are likely to have lower premiums and higher out-of-pocket costs; whereas platinum plans have higher premiums and lower out-of-pocket costs.

Generally, platinum plans would be the most cost-effective choice for individuals who plan to utilize many health care services. Gold plans would be recommended to those who utilize health care services frequently; silver plans would be recommended to those who utilize a moderate amount of health care services. Bronze would be the most cost-effective choice for individuals who don't utilize health care services very often.

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**How are the tax credits used?**

The amount a household receives in tax credits can be used to buy any plan, not just the second lowest-cost silver plan. A household could select a more expensive plan and pay more of the cost of the premium or a less expensive plan and pay less of the cost of the premium.

The tax credit is sent to the health insurance company every month, so the bill that goes to the consumer is lower. A household could choose to have the entire tax credit sent to the health insurance company each month, or they could choose to have a smaller amount sent. In that case, they would pay more towards their premiums during the year, but would get more money back when they submit their taxes.

Note: Tax credits are determined by estimated income and are reconciled just like federal income tax. This means that you may receive a refund or owe additional money to the federal government depending on your actual income that year.

**Is this what I will pay for health insurance?**

No. These rates are only samples to give you an idea of what you could pay. To determine the amount of the tax credit for which your household is eligible and to see plans available in your area, visit www.MarylandHealthConnection.gov, call our consumer support center at 1-855- 642-8572, or 1-855-642-8573 for individuals who are deaf or hard of hearing or visit a local organization where someone can help you in person. You can find a list of these organizations at www.MarylandHealthConnection.gov under Consumer Assistance.


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Sample Household #1

Household Composition: Single Individual, Age 21
Tobacco Status: Non-Tobacco User
Annual Income: $25,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

| Monthly Tax Credit: $35.83 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $114 | **$78.17** |
| Lowest Cost Silver Plan | $179 | **$143.17** |
| Second Lowest Cost Silver Plan | $180 | **$144.17** |
| Lowest Cost Gold Plan | $204 | **$168.17** |
| Lowest Cost Platinum Plan | $289 | **$253.17** |

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

| Monthly Tax Credit: $32.83 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $112.00 | **$79.17** |
| Lowest Cost Silver Plan | $175.00 | **$142.17** |
| Second Lowest Cost Silver Plan | $177.00 | **$144.17** |
| Lowest Cost Gold Plan | $200.00 | **$167.17** |
| Lowest Cost Platinum Plan | $283.00 | **$250.17** |

Washington DC Metropolitan (Montgomery County and Prince George's County)

| Monthly Tax Credit: $23.83 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $107.00 | **$ 83.17** |
| Lowest Cost Silver Plan | $166.00 | **$ 142.17** |
| Second Lowest Cost Silver Plan | $168.00 | **$ 144.17** |
| Lowest Cost Gold Plan | $190.00 | **$ 166.17** |
| Lowest Cost Platinum Plan | $269.00 | **$ 245.17** |

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

| Monthly Tax Credit: $21.83 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $105.00 | **$ 83.17** |
| Lowest Cost Silver Plan | $165.00 | **$ 143.17** |
| Second Lowest Cost Silver Plan | $166.00 | **$ 144.17** |
| Lowest Cost Gold Plan | $188.00 | **$ 166.17** |
| Lowest Cost Platinum Plan | $266.00 | **$ 244.17** |


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Sample Household #2

Household Composition: Single Individual, Age 64
Tobacco Status: Non-Tobacco User
Annual Income: $36,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

| Monthly Tax Credit: $256.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $343 | **$87.00** |
| Lowest Cost Silver Plan | $536 | **$280.00** |
| Second Lowest Cost Silver Plan | $541 | **$285.00** |
| Lowest Cost Gold Plan | $613 | **$357.00** |
| Lowest Cost Platinum Plan | $866 | **$610.00** |

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

| Monthly Tax Credit: $245.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $337 | **$92.00** |
| Lowest Cost Silver Plan | $525 | **$280.00** |
| Second Lowest Cost Silver Plan | $530 | **$285.00** |
| Lowest Cost Gold Plan | $601 | **$356.00** |
| Lowest Cost Platinum Plan | $849 | **$604.00** |

Washington DC Metropolitan (Montgomery County and Prince George's County)

| Monthly Tax Credit: $218.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $320 | **$102.00** |
| Lowest Cost Silver Plan | $499 | **$281.00** |
| Second Lowest Cost Silver Plan | $503 | **$285.00** |
| Lowest Cost Gold Plan | $571 | **$353.00** |
| Lowest Cost Platinum Plan | $806 | **$588.00** |

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

| Monthly Tax Credit: $213.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $316 | **$103.00** |
| Lowest Cost Silver Plan | $494 | **$281.00** |
| Second Lowest Cost Silver Plan | $498 | **$285.00** |
| Lowest Cost Gold Plan | $565 | **$352.00** |
| Lowest Cost Platinum Plan | $798 | **$585.00** |


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Sample Household #3

Household Composition: Family of 4 (Ages 60, 55, 24, 19)
Tobacco Status: Non-Tobacco User
Annual Income: $53,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

| Monthly Tax Credit: $867.88 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $753 | **$114.88 leftover*** |
| Lowest Cost Silver Plan | $1,175 | **$307.12** |
| Second Lowest Cost Silver Plan | $1,185 | **$317.12** |
| Lowest Cost Gold Plan | $1,345 | **$477.12** |
| Lowest Cost Platinum Plan | $1,900 | **$1,032.12** |

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

| Monthly Tax Credit: $844.88 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $738 | **$106.88 leftover*** |
| Lowest Cost Silver Plan | $1,152 | **$307.12** |
| Second Lowest Cost Silver Plan | $1,162 | **$317.12** |
| Lowest Cost Gold Plan | $1,318 | **$473.12** |
| Lowest Cost Platinum Plan | $1,862 | **$1,017.12** |

Washington DC Metropolitan (Montgomery County and Prince George's County)

| Monthly Tax Credit: $786.88 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $702 | **$84.88 leftover*** |
| Lowest Cost Silver Plan | $1,094 | **$307.12** |
| Second Lowest Cost Silver Plan | $1,104 | **$317.12** |
| Lowest Cost Gold Plan | $1,251 | **$464.12** |
| Lowest Cost Platinum Plan | $1,769 | **$982.12** |

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

| Monthly Tax Credit: $773.88 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $693 | **$80.88 leftover** |
| Lowest Cost Silver Plan | $1,082 | **$308.12** |
| Second Lowest Cost Silver Plan | $1,091 | **$317.12** |
| Lowest Cost Gold Plan | $1,239 | **$465.12** |
| Lowest Cost Platinum Plan | $1,750 | **$976.12** |

*Leftover funds could be used to purchase stand-alone dental coverage if dental is not covered by the health plan.


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Sample Household #4

Household Composition: Family of 5 (Ages 40, 38, 16, 14, 8)
Tobacco Status: Non-Tobacco User
Annual Income: $60,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

| Monthly Tax Credit: $451.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $508 | **$57** |
| Lowest Cost Silver Plan | $790 | **$339** |
| Second Lowest Cost Silver Plan | $797 | **$346** |
| Lowest Cost Gold Plan | $906 | **$455** |
| Lowest Cost Platinum Plan | $1,278 | **$827** |

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

| Monthly Tax Credit: $436.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $496 | **$60** |
| Lowest Cost Silver Plan | $775 | **$339** |
| Second Lowest Cost Silver Plan | $782 | **$346** |
| Lowest Cost Gold Plan | $887 | **$451** |
| Lowest Cost Platinum Plan | $1,255 | **$819** |

Washington DC Metropolitan (Montgomery County and Prince George's County)

| Monthly Tax Credit: $398.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $473 | **$75** |
| Lowest Cost Silver Plan | $738 | **$340** |
| Second Lowest Cost Silver Plan | $744 | **$346** |
| Lowest Cost Gold Plan | $843 | **$445** |
| Lowest Cost Platinum Plan | $1,192 | **$794** |

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

| Monthly Tax Credit: $388.00 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $467 | **$79** |
| Lowest Cost Silver Plan | $727 | **$339** |
| Second Lowest Cost Silver Plan | $734 | **$346** |
| Lowest Cost Gold Plan | $836 | **$448** |
| Lowest Cost Platinum Plan | $1,178 | **$790** |

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Sample Household #5

Household Composition: Couple (Ages 40 and 38)
Tobacco Status: Non-Tobacco User
Annual Income: $32,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

| Monthly Tax Credit: $281.13 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $289 | **$8** |
| Lowest Cost Silver Plan | $451 | **$170** |
| Second Lowest Cost Silver Plan | $455 | **$174** |
| Lowest Cost Gold Plan | $516 | **$235** |
| Lowest Cost Platinum Plan | $729 | **$448** |

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

| Monthly Tax Credit: $272.13 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $283 | **$11** |
| Lowest Cost Silver Plan | $442 | **$170** |
| Second Lowest Cost Silver Plan | $446 | **$174** |
| Lowest Cost Gold Plan | $506 | **$234** |
| Lowest Cost Platinum Plan | $715 | **$443** |

Washington DC Metropolitan (Montgomery County and Prince George's County)

| Monthly Tax Credit: $249.13 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $269 | **$20** |
| Lowest Cost Silver Plan | $420 | **$171** |
| Second Lowest Cost Silver Plan | $423 | **$174** |
| Lowest Cost Gold Plan | $480 | **$231** |
| Lowest Cost Platinum Plan | $679 | **$430** |

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

| Monthly Tax Credit: $245.13 | No Financial Assistance | **With Tax Credit** |
|---|---|---|
| Lowest Cost Bronze Plan | $266 | **$21** |
| Lowest Cost Silver Plan | $415 | **$170** |
| Second Lowest Cost Silver Plan | $419 | **$174** |
| Lowest Cost Gold Plan | $476 | **$231** |
| Lowest Cost Platinum Plan | $671 | **$426** |


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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 ("MHCRCC") 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[1]. Therefore, in accordance with the proposed rule the MHCRCC supplemented the benchmark plan with the Maryland Children's Health Insurance Plan dental benefit and the FEP Blue Vision high plan, respectively. The MHCRCC has also determined that the adult habilitative benefits will equal the rehabilitative benefits in the benchmark plan.

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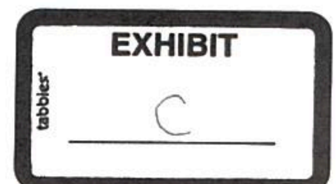
[1] The proposed rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* ("proposed rule") *See* 77 Fed. Reg. 70, 644 (proposed Nov. 26, 2012)(to be codified at 45 C.F.R. pts. 147, 155, 156).



The chosen benchmark plan also needed to be enhanced for mental health and substance use disorder services. The MHCRCC 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[2] in accordance with the Maryland Children's Health Insurance Plan dental benefit, which includes benefits for:

[2] 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.[3]

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.

[3] 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*

Brenda A. Wilson
Associate Commissioner
Life and Health

# MARYLAND EHB BENCHMARK PLAN

## SUMMARY INFORMATION

| | |
|---|---|
| **Plan Type** | Plan from largest small group product, Health Maintenance Organization |
| **Issuer Name** | CareFirst BlueChoice, Inc. |
| **Product Name** | Blue Choice HMO HSA Open Access |
| **Plan Name** | Blue Choice HMO HSA Open Access |
| **Supplemented Categories** (Supplementary Plan Type) | • Pediatric Oral (State CHIP)<br>• Pediatric Vision (FEDVIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | Yes |
| **Habilitative Services Defined by State** (Yes/No) | Yes: Habilitative benefits in the State's EHB benchmark require plans to cover habilitative services benefits for members age 19 and above in parity with benefits covered for rehabilitative services. |

## Benefits and Limits

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Primary Care Visit to Treat an Injury or Illness | Covered | PCP visit to treat an injury or illness | No | | | | | | | No |
| 2 | Specialist Visit | Covered | Specialist visit | No | | | | | | | No |
| 3 | Other Practitioner Office Visit (Nurse, Physician Assistant) | Covered | Other practitioner office visit | No | | | | | | | No |
| 4 | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Covered | Outpatient Facility Services | No | | | | | | | No |
| 5 | Outpatient Surgery Physician/Surgical Services | Covered | Outpatient Surgery Physician/ Surgical Services | No | | | | | | | No |
| 6 | Hospice Services | Covered | Hospice Care | No | | | | | | | No |
| 7 | Non-Emergency Care When Traveling Outside the U.S. | Not Covered | | | | | | | | | |
| 8 | Routine Dental Services (Adult) | Not Covered | | | | | | | | | |
| 9 | Infertility Treatment | Covered | Infertility Services | No | | | | | In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures. | | No |
| 10 | Long-Term/ Custodial Nursing Home Care | Not Covered | | | | | | | | | |
| 11 | Private-Duty Nursing | Not Covered | | | | | | | | | |

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | Routine Eye Exam (Adult) | Covered | Routine Eye Exam (Adult) | Yes | 1 | Other | Per contract year | | | | No |
| 13 | Urgent Care Centers or Facilities | Covered | Urgent Care Facility | No | | | | | | | No |
| 14 | Home Health Care Services | Covered | Home Health Care Services | No | | | | | | | No |
| 15 | Emergency Room Services | Covered | Emergency Room Services | No | | | | | | | No |
| 16 | Emergency Transportation/ Ambulance | Covered | Ambulance Services | No | | | | | | | No |
| 17 | Inpatient Hospital Services (e.g., Hospital Stay) | Covered | Hospital Inpatient Services | No | | | | | | | No |
| 18 | Inpatient Physician and Surgical Services | Covered | Inpatient physician and surgical services | No | | | | | | | No |
| 19 | Bariatric Surgery | Covered | Surgical treatment of morbid obesity | No | | | | | | | No |
| 20 | Cosmetic Surgery | Not Covered | | | | | | | | | |
| 21 | Skilled Nursing Facility | Covered | Skilled Nursing Facility | Yes | 100 | Other | Days/contract year | | | | No |
| 22 | Prenatal and Postnatal Care | Covered | Prenatal and Post Natal Care | No | | | | | | | No |
| 23 | Delivery and All Inpatient Services for Maternity Care | Covered | Delivery and all inpatient services for maternity care | No | | | | | | | No |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 24 | Mental/Behavioral Health Outpatient Services | Covered | Outpatient hospital and emergency room (non-accidental injury) mental/ behavioral health services | No | | | | | - Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems<br>- Treatment for learning disabilities and mental retardation<br>- Telephone therapy<br>- Travel time to the member's home to conduct therapy<br>- Services rendered or billed by schools, or halfway houses or members of their staffs<br>- Marriage counseling<br>- Services that are not medically necessary. | Covered services include the following:<br>- services such as partial hospitalization or intensive day treatment programs<br>- outpatient services and supplies billed by a hospital for emergency room treatment. | No |
| 25 | Mental/Behavioral Health Inpatient Services | Covered | Inpatient hospital and inpatient residential treatment centers (RTC) mental/behavioral health services | No | | | | | - Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems<br>- Treatment for learning disabilities and mental retardation<br>- Telephone therapy<br>- Travel time to the member's home to conduct therapy<br>- Services rendered or billed by schools, or halfway houses or members of their staffs<br>- Marriage counseling<br>- Services that are not medically necessary. | Covered services include the following:<br>- Room and board, such as:<br>- Ward, semiprivate, or intensive care accommodations<br>- General nursing care<br>- Meals and special diets<br>- Services provided by a hospital or licensed residential treatment center (RTC). | No |

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | Substance Abuse Disorder Outpatient Services | Covered | Outpatient hospital and emergency room (non-accidental injury) substance abuse disorder services | No | | | | | - Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems<br>- Treatment for learning disabilities and mental retardation<br>- Telephone therapy<br>- Travel time to the member's home to conduct therapy<br>- Services rendered or billed by schools, or halfway houses or members of their staffs<br>- Marriage counseling<br>- Services that are not medically necessary. | Covered services include the following:<br>- services such as partial hospitalization or intensive day treatment programs<br>- outpatient services and supplies billed by a hospital for emergency room treatment. | No |
| 27 | Substance Abuse Disorder Inpatient Services | Covered | Inpatient hospital and inpatient residential treatment centers (RTC) substance abuse disorder services | No | | | | | - Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems<br>- Treatment for learning disabilities and mental retardation<br>- Telephone therapy<br>- Travel time to the member's home to conduct therapy<br>- Services rendered or billed by schools, or halfway houses or members of their staffs<br>- Marriage counseling<br>- Services that are not medically necessary. | Covered services include the following:<br>- Room and board, such as:<br>- Ward, semiprivate, or intensive care accommodations<br>- General nursing care<br>- Meals and special diets<br>- Services provided by a hospital or licensed residential treatment center (RTC). | No |
| 28 | Generic Drugs | Covered | Generic Drugs | No | | | | | | | No |

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 29 | Preferred Brand Drugs | Covered | Preferred Brand Drugs | No | | | | | | | No |
| 30 | Non-Preferred Brand Drugs | Covered | Non-Preferred Brand Drugs | No | | | | | | | No |
| 31 | Specialty Drugs | Covered | Specialty Drugs | No | | | | | | | No |
| 32 | Outpatient Rehabilitation Services | Covered | Outpatient Rehabilitation Services (Physical Therapy, Speech Therapy, and Occupational Therapy) | Yes | 30 | Other | 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy) | | | | No |
| 33 | Habilitation Services | Covered | Habilitative services for Members from birth to age 19; habilitative services in parity with rehabilitative services for Members age 19 and above | Yes | 30 | Other | For members age 19 and above: 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy) | | | For Members from birth to age 19, habilitative services means services, including occupational therapy, physical therapy, speech therapy, orthodontics, oral surgery, otologic and audiological therapy for the treatment of children with congenital and genetic birth defects to enhance the child's ability to function.<br><br>For Members age 19 and above, habilitative services means physical therapy, speech therapy, and occupational therapy in parity with outpatient rehabilitative services. | No |
| 34 | Chiropractic Care | Covered | Chiropractic Services | Yes | 20 | Other | Visits per condition per contract year | | | | No |
| 35 | Durable Medical Equipment | Covered | Durable Medical Equipment | No | | | | | | | No |
| 36 | Hearing Aids | Covered | Hearing Aids for Minor Children | Yes | 1 | Other | Hearing aid per each hearing impaired ear every 36 months | | Hearing aids for Members over age 18 are not covered. | | No |

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 37 | Diagnostic Test (X-Ray and Lab Work) | Covered | Diagnostic Test (x-ray and lab work) | No | | | | | | | No |
| 38 | Imaging (CT/PET Scans, MRIs) | Covered | Imaging (CT/PET scans, MRIs) | No | | | | | | | No |
| 39 | Preventive Care/ Screening/ Immunization | Covered | Preventive Care/Screening/ Immunization | No | | | | | | The following preventive care services are covered:<br>(1) Evidence–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; recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.<br>(2) Immunizations for routine use in children, adolescents, and adults 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;<br>(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<br>(4) With respect to women, evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. | No |
| 40 | Routine Foot Care | Not Covered | | | | | | | | | |
| 41 | Acupuncture | Covered | Acupuncture | No | | | | | | | No |

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 42 | Weight Loss Programs | Not Covered | | | | | | | | | |
| 43 | Routine Eye Exam for Children | Covered | Routine Eye Exam (Children) | Yes | 1 | Other | Visit/contract year | | | FEDVIP BlueVision High. | No |
| 44 | Eye Glasses for Children | Covered | Glasses and Frames or Contact Lenses | Yes | 1 | Other | 1 pair of eyeglasses or 1 pair contact lenses per year | | | FEDVIP BlueVision High. | No |
| 45 | Dental Check-Up for Children | Covered | Clinical Oral Exam | Yes | 2 | Visits per year | Only fluoride from PCP, exam covered under dental plan | | | MCHP Healthy Smiles. | No |

## OTHER BENEFITS

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Other | Covered | Nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease | Yes | 6 | Other | Visits per condition per contract year | | | | No |
| 2 | Other | Covered | Autologous and nonautologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants | No | | | | | | | No |
| 3 | Other | Covered | All non-experimental/investigational solid organ transplant, and other non-solid organ transplant procedures | No | | | | | | Covered Services include the cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of eighteen (18) years), to and from the site of the transplant. | No |
| 4 | Other | Covered | Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders | No | | | | | | | No |
| 5 | Other | Covered | Professional nutritional counseling for members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness or condition | No | | | | | | | No |
| 6 | Other | Covered | Medical nutrition therapy to treat a chronic illness or condition | No | | | | | | | No |
| 7 | Other | Covered | Office visits for treatment of childhood obesity | No | | | | | | | No |
| 8 | Other | Covered | Well child care visits for obesity evaluation and management | No | | | | | | | No |
| 9 | Other | Covered | Pulmonary rehabilitation services are provided to Members who have been diagnosed with significant pulmonary disease or who have undergone certain surgical procedures of the lung | Yes | 1 | Other | Program per lifetime | | | | No |

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | Other | Covered | Diabetes treatment, equipment and supplies | No | | | | | | Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for Insulin-Using Beneficiaries. Insulin pumps are included. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the prescription drug coverage for Insulin-Using Beneficiaries. | No |
| 11 | Other | Covered | Increased outpatient rehabilitation (physical therapy, speech therapy, occupational therapy) benefits for cardiac rehabilitation | Yes | 90 | Other | Visits per therapy per contract year | | | | No |
| 12 | Other | Covered | Controlled clinical trials | No | | | | | | | No |
| 13 | Other | Covered | Reconstructive breast surgery and breast prosthesis | No | | | | | | Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts including, all stages of reconstructive breast surgery performed on a nondiseased breast to reestablish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy. | No |

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | Other | Covered | General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a Member seven years of age or younger or is developmentally disabled: or extremely uncooperative, fearful, or uncommunicative children 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity | No | | | | | | | No |
| 15 | Other | Covered | Any other service approved by the plan's case management program | No | | | | | | | No |
| 16 | Other | Covered | Services for cleft lip and cleft palate, including orthodontics, oral surgery, otologic, audiological, and speech therapy, for Members from birth to age 19 | No | | | | | | | No |
| 17 | Other | Covered | Cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums, including: autologous services; whole blood; red blood cells; platelets; plasma; immunoglobulin; and albumin | No | | | | | | | No |
| 18 | Other | Covered | Coordination of care provided through the Patient-Centered Medical Home Program | No | | | | | | Benefits will be provided for associated costs for coordination of care for the Qualifying Individual's medical conditions. | No |
| 19 | Other | Covered | Abortion services | No | | | | | | | No |

| Row Number | A Benefit | B Covered (Required): Is benefit Covered or Not Covered | C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I Exclusions (Optional): Enter any Exclusions for this benefit | J Explanation: (Optional) Enter an Explanation for anything not listed | K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 20 | Other | Covered | Professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license | No | | | | | - Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems<br>- Treatment for learning disabilities and mental retardation<br>- Telephone therapy<br>- Travel time to the member's home to conduct therapy<br>- Services rendered or billed by schools, or halfway houses or members of their staffs<br>- Marriage counseling<br>- Services that are not medically necessary. | Covered services include the following:<br>- Diagnostic evaluation<br>- Crisis intervention and stabilization for acute episodes<br>- Medication evaluation and management (pharmacotherapy)<br>- Treatment and counseling (including individual or group therapy visits)<br>- Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling<br>- Professional charges for intensive outpatient treatment in a provider's office or other professional setting<br>- Electroconvulsive therapy<br>- Inpatient professional fees. | No |
| 21 | Other | Covered | Diagnostics for mental/behavioral health and substance abuse disorders | No | | | | | | Covered diagnostic services include the following:<br>- Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner<br>- Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility<br>- Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment. | No |

## Prescription Drug EHB-Benchmark Plan Benefits by Category and Class

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANALGESICS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 19 |
| ANALGESICS | OPIOID ANALGESICS, LONG-ACTING | 6 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 8 |
| ANESTHETICS | LOCAL ANESTHETICS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | ALCOHOL DETERRENTS/ANTI-CRAVING | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | OPIOID ANTAGONISTS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | SMOKING CESSATION AGENTS | 0 |
| ANTI-INFLAMMATORY AGENTS | GLUCOCORTICOIDS | 1 |
| ANTI-INFLAMMATORY AGENTS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 19 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 4 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 10 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 8 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 0 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 5 |
| ANTIBACTERIALS | MACROLIDES | 3 |
| ANTIBACTERIALS | QUINOLONES | 4 |
| ANTIBACTERIALS | SULFONAMIDES | 4 |
| ANTIBACTERIALS | TETRACYCLINES | 4 |
| ANTICONVULSANTS | ANTICONVULSANTS, OTHER | 1 |
| ANTICONVULSANTS | CALCIUM CHANNEL MODIFYING AGENTS | 2 |
| ANTICONVULSANTS | GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS | 3 |
| ANTICONVULSANTS | GLUTAMATE REDUCING AGENTS | 3 |
| ANTICONVULSANTS | SODIUM CHANNEL AGENTS | 3 |
| ANTIDEMENTIA AGENTS | ANTIDEMENTIA AGENTS, OTHER | 1 |
| ANTIDEMENTIA AGENTS | CHOLINESTERASE INHIBITORS | 3 |
| ANTIDEMENTIA AGENTS | N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST | 1 |
| ANTIDEPRESSANTS | ANTIDEPRESSANTS, OTHER | 6 |
| ANTIDEPRESSANTS | MONOAMINE OXIDASE INHIBITORS | 2 |
| ANTIDEPRESSANTS | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 7 |
| ANTIDEPRESSANTS | TRICYCLICS | 9 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 7 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 4 |
| ANTIFUNGALS | NO USP CLASS | 13 |
| ANTIGOUT AGENTS | NO USP CLASS | 4 |
| ANTIMIGRAINE AGENTS | ERGOT ALKALOIDS | 1 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANTIMIGRAINE AGENTS | PROPHYLACTIC | 3 |
| ANTIMIGRAINE AGENTS | SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS | 2 |
| ANTIMYASTHENIC AGENTS | PARASYMPATHOMIMETICS | 2 |
| ANTIMYCOBACTERIALS | ANTIMYCOBACTERIALS, OTHER | 1 |
| ANTIMYCOBACTERIALS | ANTITUBERCULARS | 5 |
| ANTINEOPLASTICS | ALKYLATING AGENTS | 5 |
| ANTINEOPLASTICS | ANTIANGIOGENIC AGENTS | 2 |
| ANTINEOPLASTICS | ANTIESTROGENS/MODIFIERS | 3 |
| ANTINEOPLASTICS | ANTIMETABOLITES | 1 |
| ANTINEOPLASTICS | ANTINEOPLASTICS, OTHER | 2 |
| ANTINEOPLASTICS | AROMATASE INHIBITORS, 3RD GENERATION | 3 |
| ANTINEOPLASTICS | ENZYME INHIBITORS | 1 |
| ANTINEOPLASTICS | MOLECULAR TARGET INHIBITORS | 12 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 0 |
| ANTINEOPLASTICS | RETINOIDS | 2 |
| ANTIPARASITICS | ANTHELMINTICS | 1 |
| ANTIPARASITICS | ANTIPROTOZOALS | 6 |
| ANTIPARASITICS | PEDICULICIDES/SCABICIDES | 3 |
| ANTIPARKINSON AGENTS | ANTICHOLINERGICS | 2 |
| ANTIPARKINSON AGENTS | ANTIPARKINSON AGENTS, OTHER | 1 |
| ANTIPARKINSON AGENTS | DOPAMINE AGONISTS | 4 |
| ANTIPARKINSON AGENTS | DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS | 1 |
| ANTIPARKINSON AGENTS | MONOAMINE OXIDASE B (MAO-B) INHIBITORS | 1 |
| ANTIPSYCHOTICS | 1ST GENERATION/TYPICAL | 9 |
| ANTIPSYCHOTICS | 2ND GENERATION/ATYPICAL | 5 |
| ANTIPSYCHOTICS | TREATMENT-RESISTANT | 1 |
| ANTISPASTICITY AGENTS | NO USP CLASS | 3 |
| ANTIVIRALS | ANTI-CYTOMEGALOVIRUS (CMV) AGENTS | 1 |
| ANTIVIRALS | ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS | 5 |
| ANTIVIRALS | ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS | 11 |
| ANTIVIRALS | ANTI-HIV AGENTS, OTHER | 3 |
| ANTIVIRALS | ANTI-HIV AGENTS, PROTEASE INHIBITORS | 9 |
| ANTIVIRALS | ANTI-INFLUENZA AGENTS | 2 |
| ANTIVIRALS | ANTIHEPATITIS AGENTS | 5 |
| ANTIVIRALS | ANTIHERPETIC AGENTS | 4 |
| ANXIOLYTICS | ANXIOLYTICS, OTHER | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANXIOLYTICS | SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/ SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS) | 4 |
| BIPOLAR AGENTS | BIPOLAR AGENTS, OTHER | 5 |
| BIPOLAR AGENTS | MOOD STABILIZERS | 5 |
| BLOOD GLUCOSE REGULATORS | ANTIDIABETIC AGENTS | 15 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 0 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 6 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | ANTICOAGULANTS | 5 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | BLOOD FORMATION MODIFIERS | 4 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | COAGULANTS | 0 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | PLATELET MODIFYING AGENTS | 4 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC AGONISTS | 5 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC BLOCKING AGENTS | 3 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN II RECEPTOR ANTAGONISTS | 5 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS | 10 |
| CARDIOVASCULAR AGENTS | ANTIARRHYTHMICS | 7 |
| CARDIOVASCULAR AGENTS | BETA-ADRENERGIC BLOCKING AGENTS | 12 |
| CARDIOVASCULAR AGENTS | CALCIUM CHANNEL BLOCKING AGENTS | 9 |
| CARDIOVASCULAR AGENTS | CARDIOVASCULAR AGENTS, OTHER | 3 |
| CARDIOVASCULAR AGENTS | DIURETICS, CARBONIC ANHYDRASE INHIBITORS | 2 |
| CARDIOVASCULAR AGENTS | DIURETICS, LOOP | 3 |
| CARDIOVASCULAR AGENTS | DIURETICS, POTASSIUM-SPARING | 3 |
| CARDIOVASCULAR AGENTS | DIURETICS, THIAZIDE | 6 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES | 2 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS | 5 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, OTHER | 3 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL | 2 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES | 2 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 0 |
| CENTRAL NERVOUS SYSTEM AGENTS | FIBROMYALGIA AGENTS | 0 |
| CENTRAL NERVOUS SYSTEM AGENTS | MULTIPLE SCLEROSIS AGENTS | 2 |
| DENTAL AND ORAL AGENTS | NO USP CLASS | 5 |
| DERMATOLOGICAL AGENTS | NO USP CLASS | 16 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 1 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 3 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 3 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 4 |
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 0 |
| GASTROINTESTINAL AGENTS | LAXATIVES | 1 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 3 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 3 |
| GENITOURINARY AGENTS | BENIGN PROSTATIC HYPERTROPHY AGENTS | 7 |
| GENITOURINARY AGENTS | GENITOURINARY AGENTS, OTHER | 1 |
| GENITOURINARY AGENTS | PHOSPHATE BINDERS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL) | GLUCOCORTICOIDS/MINERALOCORTICOIDS | 20 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY) | NO USP CLASS | 3 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS) | NO USP CLASS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANABOLIC STEROIDS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANDROGENS | 3 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ESTROGENS | 3 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | PROGESTINS | 4 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) | NO USP CLASS | 2 |
| HORMONAL AGENTS, SUPPRESSANT (ADRENAL) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) | NO USP CLASS | 0 |
| HORMONAL AGENTS, SUPPRESSANT (PITUITARY) | NO USP CLASS | 4 |
| HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) | ANTIANDROGENS | 5 |
| HORMONAL AGENTS, SUPPRESSANT (THYROID) | ANTITHYROID AGENTS | 2 |
| IMMUNOLOGICAL AGENTS | IMMUNE SUPPRESSANTS | 9 |
| IMMUNOLOGICAL AGENTS | IMMUNIZING AGENTS, PASSIVE | 0 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 3 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 2 |
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |

| CATEGORY | CLASS | SUBMISSION COUNT |
| --- | --- | --- |
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 6 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 2 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 4 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 3 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 7 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 12 |
| OTIC AGENTS | NO USP CLASS | 3 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 4 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 9 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 6 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 1 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 1 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 6 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 2 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 2 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 1 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 2 |