

# SENATE BILL 834

C3

5lr2947  
CF HB 990

---

By: **Senators Pugh and Benson**

Introduced and read first time: February 23, 2015

Assigned to: Rules

---

## A BILL ENTITLED

AN ACT concerning

### **Maryland Health Benefit Exchange – Qualified Health Plans – Standards**

FOR the purpose of altering certain requirements for certification as a qualified health plan in the Maryland Health Benefit Exchange; prohibiting a qualified health plan from using a benefit design or implementing a benefit design in a manner that discriminates in a certain manner; prohibiting a qualified health plan from utilizing a certain management technique except under certain circumstances; requiring certain carriers to submit to the Exchange certain information at a certain time and in a certain manner; requiring the Exchange to perform a certain evaluation on or before a certain date; prohibiting certain carriers from making certain formulary changes during a certain period with a certain exception; authorizing certain carriers to make a certain formulary change under a certain circumstance; requiring a qualified health plan formulary to be reviewed by a certain pharmacy and therapeutics committee; establishing certain membership requirements for the committee; requiring the committee to perform a certain review in a certain manner and to make recommendations regarding certain matters; authorizing the committee to perform a certain review and make certain recommendations on certain prescription drugs in a certain manner under certain circumstances; requiring meetings of the committee to occur at a certain frequency; requiring certain carriers to make certain information available to the public in a certain manner; establishing certain provider network requirements for qualified health plans; requiring the Exchange and the Maryland Insurance Commissioner to establish certain standards; requiring certain carriers to submit to the Exchange and the Commissioner certain information at a certain time and in a certain manner; requiring the Exchange and the Commissioner to review certain information to make a certain determination; requiring certain carriers to authorize the receipt of certain services from certain providers under certain circumstances; prohibiting certain carriers from requiring an enrollee to pay a certain deductible, copayment, or coinsurance amount for certain services under a certain circumstance; requiring certain essential health benefits to include a certain benefit that consists of prescription drugs that are offered in a certain manner; prohibiting a carrier from assigning a certain drug to a certain tier

---

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



except under certain circumstances; establishing certain requirements for certain qualified health plan deductibles; requiring the Board of Trustees of the Maryland Health Benefit Exchange to submit certain reports to the Governor and the General Assembly on or before certain dates; requiring the Exchange to make available to certain enrollees and the public certain information; defining certain terms; providing for the application of this Act; and generally relating to the Maryland Health Benefit Exchange and standards for qualified health plans.

BY repealing and reenacting, with amendments,

Article – Insurance

Section 31–115(b) and (k)(2), 31–116(a), and 31–119(d)

Annotated Code of Maryland

(2011 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, without amendments,

Article – Insurance

Section 31–115(k)(1)

Annotated Code of Maryland

(2011 Replacement Volume and 2014 Supplement)

BY adding to

Article – Insurance

Section 31–115.1 through 31–115.3 and 31–119(f)

Annotated Code of Maryland

(2011 Replacement Volume and 2014 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,  
That the Laws of Maryland read as follows:

### **Article – Insurance**

31–115.

(b) To be certified as a qualified health plan, a health benefit plan shall:

(1) except as provided in subsection (c) of this section, provide the essential health benefits required under § 1302(a) of the Affordable Care Act and § 31–116 of this title;

(2) obtain prior approval of premium rates and contract language from the Commissioner;

(3) except as provided in subsection (e) of this section, provide at least a bronze level of coverage, as defined in the Affordable Care Act and determined by the Exchange under § 31–108(b)(8)(ii) of this title;

(4) (i) ensure that its cost-sharing requirements do not exceed the limits established under § 1302(c)(1) of the Affordable Care Act; and

(ii) if the health benefit plan is offered through the SHOP Exchange, ensure that the health benefit plan's deductible does not exceed the limits established under § 1302(c)(2) of the Affordable Care Act;

(5) be offered by a carrier that:

(i) is licensed and in good standing to offer health insurance coverage in the State;

(ii) offers in each Exchange, the Individual and the SHOP, in which the carrier participates, at least one qualified health plan:

1. at a bronze level of coverage;
2. at a silver level of coverage; and
3. at a gold level of coverage;

(iii) if the carrier participates in the Individual Exchange and offers any health benefit plan in the individual market outside the Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange;

(iv) if the carrier participates in the SHOP Exchange and offers any health benefit plan in the small group market outside the SHOP Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the small group market outside the SHOP Exchange;

(v) charges the same premium rate for each qualified health plan regardless of whether the qualified health plan is offered through the Exchange, through an insurance producer outside the Exchange, or directly from a carrier;

(vi) does not charge any cancellation fees or penalties in violation of § 31-108(d) of this title; and

(vii) complies with the regulations adopted by the Secretary under § 1311(d) of the Affordable Care Act and by the Exchange under § 31-106(c)(1)(iv) of this title;

(6) meet the requirements for certification established under the regulations adopted by:

(i) the Secretary under § 1311(c)(1) of the Affordable Care Act, including minimum standards for marketing practices, network adequacy, essential

community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance; and

(ii) the Exchange under § 31–106(c)(1)(iv) of this title;

(7) be in the interest of qualified individuals and qualified employers, as determined by the Exchange;

(8) provide any other benefits as may be required by the Commissioner under any applicable State law or regulation; [and]

**(9) HAVE A BENEFIT DESIGN AND BE ADMINISTERED IN A MANNER THAT COMPLIES WITH § 31–115.1 OF THIS TITLE;**

**(10) BE ADMINISTERED IN A MANNER THAT COMPLIES WITH THE FORMULARY MANAGEMENT REQUIREMENTS UNDER § 31–115.2 OF THIS TITLE;**

**(11) MEET THE REQUIREMENTS RELATING TO NETWORK ADEQUACY ESTABLISHED UNDER § 31–115.3 OF THIS TITLE; AND**

**[(9)] (12)** meet any other requirements established by the Exchange under this title, including:

(i) transition of care language in contracts as determined appropriate by the Exchange to ensure care continuity and reduce duplication and costs of care;

(ii) criteria that encourage and support qualified plans in facilitating cross–border enrollment; and

(iii) demonstrating compliance with the federal Mental Health Parity and Addiction Equity Act of 2008.

(k) (1) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, and subsection (f) of this section, and except as provided in subsection (l)(2) of this section, the Exchange may deny certification to a health benefit plan, a dental plan, or a vision plan, or suspend or revoke the certification of a qualified plan, based on a finding that the health benefit plan, dental plan, vision plan, or qualified plan does not satisfy requirements or has otherwise violated standards for certification that are:

(i) established under the regulations and interim policies adopted by the Exchange to carry out this title; and

(ii) not otherwise under the regulatory and enforcement authority of the Commissioner.

(2) Certification requirements shall include providing data and meeting standards related to:

- (i) enrollment;
- (ii) essential community providers;
- (iii) complaints and grievances involving the Exchange;
- (iv) network adequacy;
- (v) quality;
- (vi) transparency;
- (vii) race, ethnicity, language, interpreter need, and cultural competency (RELICC);
- (viii) plan service area, including demographics;
- (ix) accreditation; [and]
- (x) complying with fair marketing standards developed jointly by the Exchange and the Commissioner;

**(XI) BENEFIT DESIGN; AND**

**(XII) FORMULARY MANAGEMENT PRACTICES.**

**31-115.1.**

**(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

**(2) “BENEFIT DESIGN” INCLUDES:**

**(I) THE CATEGORIES OF BENEFITS INCLUDED IN A HEALTH BENEFIT PLAN;**

**(II) THERAPIES OR CONDITIONS EXPRESSLY EXCLUDED FROM COVERAGE;**

(III) THE MANNER IN WHICH COVERAGE DECISIONS ARE MADE BY THE CARRIER UNDER THE HEALTH BENEFIT PLAN;

(IV) DIFFERENTIAL REIMBURSEMENT RATES OR COST SHARING FOR COVERED BENEFITS;

(V) CLINICAL PREREQUISITES OR HEIGHTENED ADMINISTRATIVE REQUIREMENTS BASED ON AN ENROLLEE'S DISEASE, DISABILITY, QUALITY OF LIFE, OR EXPECTED LENGTH OF LIFE;

(VI) INCENTIVE PROGRAMS; AND

(VII) PROCESSES FOR APPEALING OR FILING AN EXCEPTION TO ANY DENIAL OF COVERAGE, INCLUDING A DENIAL OF COVERAGE ON THE GROUND THAT AN ITEM OR A SERVICE IS NOT MEDICALLY NECESSARY.

(3) "DISCRIMINATORY MEDICAL MANAGEMENT TECHNIQUE" MEANS A TECHNIQUE:

(I) USED FOR DETERMINING COVERAGE UNDER A HEALTH BENEFIT PLAN OF A TREATMENT ORDERED FOR AN INDIVIDUAL BY THE INDIVIDUAL'S PHYSICIAN; AND

(II) THAT APPLIES ONLY TO:

1. SPECIFIED DISEASES OR CONDITIONS; OR
2. SUBSETS OF PATIENTS OR ENROLLEES OF A HEALTH BENEFIT PLAN.

(4) "GENERALLY ACCEPTED BEST MEDICAL PRACTICE" MEANS A MEDICAL PRACTICE THAT IS:

(I) SUPPORTED BY PEER-REVIEWED MEDICAL JOURNALS; OR

(II) IN ACCORDANCE WITH STANDARDS OF CARE ADOPTED BY MEDICAL SPECIALTY SOCIETIES.

(B) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A QUALIFIED HEALTH PLAN MAY NOT USE A BENEFIT DESIGN OR IMPLEMENT A BENEFIT DESIGN IN A MANNER THAT DISCRIMINATES ON THE BASIS OF AN INDIVIDUAL'S:

(I) AGE;

- (II) EXPECTED LENGTH OF LIFE;
- (III) RACE;
- (IV) COLOR;
- (V) NATIONAL ORIGIN;
- (VI) SEX;
- (VII) GENDER IDENTITY;
- (VIII) SEXUAL ORIENTATION;
- (IX) PRESENT OR PREDICTED DISABILITY;
- (X) DEGREE OF MEDICAL DEPENDENCY;
- (XI) QUALITY OF LIFE; OR
- (XII) PRESENT OR PREDICTED DIAGNOSIS, DISEASE, OR HEALTH CONDITION.

(2) A QUALIFIED HEALTH PLAN MAY NOT UTILIZE A DISCRIMINATORY MEDICAL MANAGEMENT TECHNIQUE UNLESS THE TECHNIQUE IS BASED ON GENERALLY ACCEPTED BEST MEDICAL PRACTICES FOR THE TREATMENT OF A DISEASE, CONDITION, OR CATEGORY OF PATIENTS.

(C) (1) EACH CARRIER THAT OFFERS A QUALIFIED HEALTH PLAN SHALL SUBMIT TO THE EXCHANGE, ON AN ANNUAL BASIS AND IN THE MANNER AND FORM REQUESTED BY THE EXCHANGE, INFORMATION ABOUT:

(I) THE ITEMS AND SERVICES COVERED UNDER THE QUALIFIED HEALTH PLAN FOR EACH OF THE 10 ESSENTIAL HEALTH BENEFIT CATEGORIES FOR WHICH COVERAGE IS REQUIRED UNDER THE AFFORDABLE CARE ACT;

(II) ANY EXCLUSIONS OR LIMITATIONS ON ITEMS OR SERVICES UNDER THE QUALIFIED HEALTH PLAN;

(III) IF THE QUALIFIED HEALTH PLAN HAS A FORMULARY, THE FORMULARY, INCLUDING THE TIER STRUCTURE OF THE FORMULARY, A LIST OF

EACH PRESCRIPTION DRUG ON THE FORMULARY, AND THE TIER PLACEMENT OF EACH DRUG ON THE FORMULARY;

(IV) ANY USE OF A NETWORK OF HEALTH CARE PROVIDERS; AND

(V) COST-SHARING REQUIREMENTS FOR COVERED ITEMS AND SERVICES, INCLUDING ANY APPLICABLE DEDUCTIBLE, COPAYMENT, AND COINSURANCE REQUIREMENTS.

(2) A CARRIER SHALL SUBMIT THE INFORMATION REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN A MACHINE-READABLE FORMAT THAT ENABLES THE EXCHANGE TO ANALYZE AND COMPARE THE INFORMATION WITH INFORMATION SUBMITTED FOR OTHER QUALIFIED HEALTH PLANS.

(D) ON OR BEFORE JUNE 1 OF EACH YEAR, THE EXCHANGE, ON THE BASIS OF THE INFORMATION PROVIDED UNDER SUBSECTION (C) OF THIS SECTION, SHALL EVALUATE WHETHER A CARRIER OFFERING A QUALIFIED HEALTH PLAN IN THE EXCHANGE IS IN COMPLIANCE WITH THE REQUIREMENTS OF THIS SECTION AND ANY NONDISCRIMINATION PROVISIONS APPLICABLE UNDER FEDERAL LAW.

31-115.2.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, DURING A PLAN YEAR AND THE OPEN ENROLLMENT PERIOD THAT PRECEDES THE PLAN YEAR, A CARRIER THAT OFFERS A QUALIFIED HEALTH PLAN MAY NOT:

(1) REMOVE A PRESCRIPTION DRUG FROM A FORMULARY;

(2) IF THE FORMULARY INCLUDES TWO OR MORE BENEFIT TIERS THAT ESTABLISH DIFFERENT DEDUCTIBLE, COPAYMENT, OR COINSURANCE REQUIREMENTS FOR PRESCRIPTION DRUGS IN EACH BENEFIT TIER, MOVE A PRESCRIPTION DRUG TO A BENEFIT TIER THAT REQUIRES AN ENROLLEE TO PAY A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE PRESCRIPTION DRUG; OR

(3) ADD A UTILIZATION MANAGEMENT RESTRICTION TO A PRESCRIPTION DRUG IN THE FORMULARY.

(B) FOR A QUALIFIED HEALTH PLAN WITH A FORMULARY THAT INCLUDES TWO OR MORE BENEFIT TIERS THAT ESTABLISH DIFFERENT DEDUCTIBLE, COPAYMENT, OR COINSURANCE REQUIREMENTS FOR PRESCRIPTION DRUGS IN EACH BENEFIT TIER, A CARRIER MAY MOVE A PRESCRIPTION DRUG TO A BENEFIT TIER THAT REQUIRES AN ENROLLEE TO PAY A HIGHER DEDUCTIBLE, COPAYMENT,

OR COINSURANCE AMOUNT FOR THE PRESCRIPTION DRUG IF, AT THE SAME TIME, THE CARRIER ADDS TO THE FORMULARY AN AB-RATED GENERIC DRUG FOR THE PRESCRIPTION DRUG.

(c) (1) A QUALIFIED HEALTH PLAN FORMULARY SHALL BE REVIEWED BY AN INDEPENDENT PHARMACY AND THERAPEUTICS COMMITTEE THAT MEETS THE CRITERIA ESTABLISHED UNDER THIS SUBSECTION.

(2) (I) A PHARMACY AND THERAPEUTICS COMMITTEE SHALL:

1. CONSIST OF MEMBERS WHO PRACTICE IN VARYING CLINICAL SPECIALTY AREAS THAT REPRESENT THE HEALTH CARE NEEDS OF ENROLLEES OF THE HEALTH BENEFIT PLAN; AND

2. INCLUDE SPECIALISTS WHO TREAT A HIGH VOLUME OF PATIENTS.

(II) A MAJORITY OF MEMBERS OF A PHARMACY AND THERAPEUTICS COMMITTEE REQUIRED UNDER THIS SUBSECTION SHALL BE PRACTICING PHYSICIANS OR PHARMACISTS LICENSED TO PRACTICE MEDICINE OR PRACTICE PHARMACY IN THE STATE.

(3) (I) A PHARMACY AND THERAPEUTICS COMMITTEE SHALL REVIEW AND MAKE RECOMMENDATIONS REGARDING:

1. THE SAFETY AND EFFICACY OF PRESCRIPTION DRUGS INCLUDED OR PROPOSED FOR INCLUSION IN A HEALTH BENEFIT PLAN FORMULARY; AND

2. WHETHER FORMULARY MANAGEMENT PRACTICES UTILIZED BY A QUALIFIED HEALTH PLAN, SUCH AS PRIOR AUTHORIZATION, STEP THERAPY, QUANTITY LIMITATIONS, AND GENERIC SUBSTITUTIONS, ARE CLINICALLY APPROPRIATE AND CONSISTENT WITH INDUSTRY STANDARDS AND GUIDELINES FROM EXPERT PATIENT ADVOCACY AND PROVIDER ORGANIZATIONS.

(II) IN PERFORMING THE REVIEW REQUIRED UNDER THIS PARAGRAPH, A PHARMACY AND THERAPEUTICS COMMITTEE SHALL:

1. BASE ITS RECOMMENDATIONS ON THE STRENGTH OF SCIENTIFIC EVIDENCE, STANDARDS OF PRACTICE, AND NATIONALLY ACCEPTED TREATMENT GUIDELINES;

2. UTILIZE A TRANSPARENT PROCESS; AND

**3. DOCUMENT ITS RECOMMENDATIONS IN WRITING.**

**(III) SUBJECT TO SUBPARAGRAPH (IV) OF THIS PARAGRAPH, A PHARMACY AND THERAPEUTICS COMMITTEE SHALL REVIEW AND MAKE A FORMULARY RECOMMENDATION ON A DRUG THAT IS NEWLY APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION WITHIN 90 DAYS AFTER THE APPROVAL OF THE DRUG.**

**(IV) A PHARMACY AND THERAPEUTICS COMMITTEE MAY REVIEW AND MAKE A RECOMMENDATION ON A PRESCRIPTION DRUG THAT IS NEWLY APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION MORE THAN 90 DAYS AFTER THE APPROVAL OF THE DRUG IF THE PHARMACY AND THERAPEUTICS COMMITTEE PROVIDES A CLINICAL JUSTIFICATION FOR THE DELAY IN REVIEWING AND MAKING ITS RECOMMENDATION ON THE DRUG.**

**(4) A PHARMACY AND THERAPEUTICS COMMITTEE SHALL MEET AT LEAST QUARTERLY.**

**(5) A CARRIER THAT OFFERS A QUALIFIED HEALTH PLAN SHALL MAKE AVAILABLE TO THE PUBLIC ON THE CARRIER'S WEB SITE FOR THE QUALIFIED HEALTH PLAN:**

**(I) RECOMMENDATIONS MADE BY THE PHARMACY AND THERAPEUTICS COMMITTEE RELATING TO THE QUALIFIED HEALTH PLAN FORMULARY, MANAGEMENT OF THE FORMULARY, AND OTHER UTILIZATION MANAGEMENT PRACTICES OF THE QUALIFIED HEALTH PLAN, INCLUDING ANY RECOMMENDED FORMULARY OR MANAGEMENT PRACTICE CHANGES; AND**

**(II) THE MEETING MINUTES OF THE PHARMACY AND THERAPEUTICS COMMITTEE.**

**31-115.3.**

**(A) A QUALIFIED HEALTH PLAN SHALL MAINTAIN AN ADEQUATE NUMBER AND GEOGRAPHIC DISTRIBUTION OF PRIMARY AND SPECIALTY HEALTH CARE PROVIDERS IN THE PLAN'S NETWORK TO MEET, WITHOUT UNREASONABLE DELAY, THE ANTICIPATED HEALTH CARE NEEDS OF ENROLLEES IN THE PLAN.**

**(B) (1) THE EXCHANGE AND THE COMMISSIONER SHALL JOINTLY ESTABLISH STANDARDS FOR QUALIFIED HEALTH PLAN NETWORK ADEQUACY.**

**(2) THE NETWORK ADEQUACY STANDARDS FOR A QUALIFIED HEALTH PLAN SHALL INCLUDE CONSIDERATION OF THE FOLLOWING FACTORS:**

**(I) THE LOCATION OF THE PARTICIPATING HEALTH CARE PROVIDERS AND FACILITIES;**

**(II) THE LOCATION OF ENROLLEES IN THE QUALIFIED HEALTH PLAN AND EMPLOYERS WHO MAKE THE QUALIFIED HEALTH PLAN AVAILABLE TO THEIR EMPLOYEES;**

**(III) THE RANGE OF SERVICES OFFERED BY PARTICIPATING HEALTH CARE PROVIDERS AND FACILITIES FOR THE QUALIFIED HEALTH PLAN;**

**(IV) THE NUMBER OF TYPES OF PARTICIPATING HEALTH CARE PROVIDERS AND FACILITIES THAT PROVIDE SERVICES IN EACH OF THE 10 CATEGORIES OF THE ESSENTIAL HEALTH BENEFITS REQUIRED UNDER § 1302(A) OF THE AFFORDABLE CARE ACT, INCLUDING THE NUMBER OF PARTICIPATING PRIMARY AND SPECIALTY HEALTH CARE PROVIDERS, PHYSICIAN OFFICES, CLINICS, HOSPITALS, AND PHARMACIES;**

**(V) THE INCLUSION OF PROVISIONS IN THE QUALIFIED HEALTH PLAN THAT RECOGNIZE AND PROVIDE FOR EXTRAORDINARY MEDICAL NEEDS OF ENROLLEES THAT CANNOT BE TREATED ADEQUATELY BY THE NETWORK'S PARTICIPATING HEALTH CARE PROVIDERS AND FACILITIES;**

**(VI) THE NUMBER AND DISTRIBUTION OF ENROLLEES LOCATED WITHIN THE GEOGRAPHIC SERVICE AREA OF THE QUALIFIED HEALTH PLAN WHO LIVE IN INSTITUTIONAL SETTINGS OR HAVE CHRONIC, SEVERE, OR DISABLING MEDICAL CONDITIONS; AND**

**(VII) WHETHER THE QUALIFIED HEALTH PLAN IS ACCREDITED FOR NETWORK ADEQUACY BY A NATIONAL ACCREDITATION ORGANIZATION, INCLUDING:**

**1. THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE;**

**2. THE JOINT COMMISSION ACCREDITATION ASSOCIATION OF AMBULATORY HEALTH CARE; AND**

**3. URAC.**

**(C) (1) A CARRIER SHALL SUBMIT TO THE EXCHANGE AND THE COMMISSIONER, ON AN ANNUAL BASIS AND IN THE MANNER AND FORM REQUESTED BY THE EXCHANGE AND THE COMMISSIONER, INFORMATION ABOUT THE NETWORK OF EACH QUALIFIED HEALTH PLAN OFFERED BY THE CARRIER AND ACTIONS TAKEN BY THE CARRIER TO ENSURE THE ADEQUACY OF ITS NETWORK.**

**(2) APPLYING THE STANDARDS FOR NETWORK ADEQUACY ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION, THE EXCHANGE AND THE COMMISSIONER SHALL REVIEW THE INFORMATION SUBMITTED BY A CARRIER UNDER PARAGRAPH (1) OF THIS SUBSECTION TO DETERMINE WHETHER A QUALIFIED HEALTH PLAN NETWORK IS ADEQUATE.**

**(D) (1) IF A QUALIFIED HEALTH PLAN NETWORK CHANGES DURING A PLAN YEAR AND NO LONGER MEETS THE NETWORK ADEQUACY STANDARDS ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION, A CARRIER SHALL AUTHORIZE THE RECEIPT OF COVERED SERVICES BY ENROLLEES FROM HEALTH CARE PROVIDERS THAT ARE NOT INCLUDED IN THE QUALIFIED HEALTH PLAN'S NETWORK.**

**(2) FOR SERVICES PROVIDED BY AN OUT-OF-NETWORK HEALTH CARE PROVIDER TO AN ENROLLEE UNDER PARAGRAPH (1) OF THIS SUBSECTION, A CARRIER MAY NOT REQUIRE AN ENROLLEE TO PAY A HIGHER DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE OUT-OF-NETWORK SERVICE THAN THE ENROLLEE WOULD BE REQUIRED TO PAY FOR THE SAME SERVICE RECEIVED FROM A PROVIDER IN THE QUALIFIED HEALTH PLAN'S NETWORK.**

31-116.

**(a) (1) IN THIS SUBSECTION, "NONPREFERRED FORMULARY TIER" MEANS A DESIGN FEATURE OF A PRESCRIPTION DRUG BENEFIT THAT SUBJECTS THE PRESCRIPTION DRUGS ASSIGNED TO THE TIER TO UTILIZATION RESTRICTIONS OR REQUIRES AN ENROLLEE TO PAY FOR PRESCRIPTION DRUGS ASSIGNED TO THE TIER A DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT THAT IS HIGHER THAN A DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT THAT AN ENROLLEE IS REQUIRED TO PAY FOR OTHER PRESCRIPTION DRUGS IN THE FORMULARY.**

**(2) The essential health benefits required under § 1302(a) of the Affordable Care Act:**

**[(1) (I) SUBJECT TO PARAGRAPHS (3) AND (4) OF THIS SUBSECTION, shall be the benefits in the State benchmark plan, selected in accordance with this section; [and]**

**[(2)] (II)** notwithstanding any other benefits mandated by State law, shall be the benefits required in:

**[(i)] 1.** subject to subsection (f) of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and

**[(ii)] 2.** subject to § 31–115(c) of this title, all qualified health plans offered in the Exchange; AND

**(III) SHALL INCLUDE A PRESCRIPTION DRUG BENEFIT THAT CONSISTS OF PRESCRIPTION DRUGS THAT ARE OFFERED IN THE MANNER REQUIRED UNDER PARAGRAPHS (3) AND (4) OF THIS SUBSECTION.**

**(3) (I) THIS PARAGRAPH APPLIES TO A QUALIFIED HEALTH PLAN WITH A PRESCRIPTION DRUG BENEFIT THAT USES A FORMULARY.**

**(II) A CARRIER MAY NOT ASSIGN A PRESCRIPTION DRUG THAT IS COVERED UNDER THE PRESCRIPTION DRUG BENEFIT TO A NONPREFERRED FORMULARY TIER UNLESS THE PRESCRIPTION DRUG BENEFIT FORMULARY INCLUDES AT LEAST ONE PRESCRIPTION DRUG THAT:**

**1. IS IN THE SAME THERAPEUTIC CLASS AS THE NONPREFERRED DRUG;**

**2. IS A MEDICALLY APPROPRIATE ALTERNATIVE TO THE NONPREFERRED DRUG; AND**

**3. IS ASSIGNED TO A FORMULARY TIER THAT REQUIRES AN ENROLLEE TO PAY A DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT FOR THE DRUG THAT IS LOWER THAN THE AMOUNT FOR THE NONPREFERRED DRUG.**

**(4) (I) THIS PARAGRAPH DOES NOT APPLY TO:**

**1. A CATASTROPHIC PLAN, AS DEFINED BY THE AFFORDABLE CARE ACT; OR**

**2. A HEALTH BENEFIT PLAN THAT PROVIDES A BRONZE LEVEL OF COVERAGE, AS DEFINED IN THE AFFORDABLE CARE ACT AND DETERMINED BY THE EXCHANGE UNDER § 31–108(B)(8)(II) OF THIS TITLE.**

**(II) IF A QUALIFIED HEALTH PLAN REQUIRES AN ENROLLEE TO PAY A DEDUCTIBLE FOR THE PLAN'S PRESCRIPTION DRUG BENEFIT:**

**1. THE DEDUCTIBLE FOR THE PRESCRIPTION DRUG BENEFIT SHALL BE SEPARATE FROM ANY DEDUCTIBLE THAT APPLIES TO ANOTHER BENEFIT OFFERED UNDER THE QUALIFIED HEALTH PLAN; AND**

**2. THE DOLLAR AMOUNT OF THE PRESCRIPTION DRUG BENEFIT DEDUCTIBLE MAY NOT EXCEED 10% OF THE DOLLAR AMOUNT OF ANY OTHER DEDUCTIBLE THAT APPLIES TO ANOTHER BENEFIT OFFERED UNDER THE QUALIFIED HEALTH PLAN FOR MEDICAL ITEMS AND SERVICES.**

31-119.

(d) (1) On or before December 1 of each year, the Board shall forward to the Secretary, the Governor, and, in accordance with § 2-1246 of the State Government Article, the General Assembly, a report on the activities, expenditures, and receipts of the Exchange.

(2) The report shall:

(i) be in the standardized format required by the Secretary;

(ii) include data regarding:

1. health plan participation, ratings, coverage, price, quality improvement measures, and benefits;

2. consumer choice, participation, and satisfaction information to the extent the information is available;

3. financial integrity, fee assessments, and status of the Fund; and

4. any other appropriate metrics related to the operation of the Exchange that may be used to evaluate Exchange performance, assure transparency, and facilitate research and analysis;

(iii) assess and, to the extent feasible and permitted by law, include data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, gender identity, sexual orientation, or other attributes of special populations; and

(iv) include information on its fraud, waste, and abuse detection and prevention program.

**(3) (1) ON OR BEFORE JUNE 1 OF EACH YEAR, THE BOARD SHALL SUBMIT A REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2-1246 OF THE**

STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON THE PROCESS BEING USED BY THE EXCHANGE TO ASSESS QUALIFIED HEALTH PLAN CARRIER COMPLIANCE WITH THE BENEFIT DESIGN REQUIREMENTS OF § 31-115.1 OF THIS TITLE.

(II) THE REPORT REQUIRED UNDER THIS PARAGRAPH SHALL INCLUDE:

1. A DETAILED DESCRIPTION OF ANY DISCRIMINATORY PRACTICES IN VIOLATION OF § 31-115.1 OF THIS TITLE THAT THE EXCHANGE IDENTIFIES AS BEING UTILIZED BY A CARRIER THAT OFFERS A QUALIFIED HEALTH PLAN IN THE EXCHANGE DURING THE COURSE OF THE PRECEDING PLAN YEAR; AND

2. ACTIONS TAKEN BY THE EXCHANGE TO:

A. ADDRESS THE DISCRIMINATORY PRACTICES IDENTIFIED UNDER ITEM 1 OF THIS SUBPARAGRAPH; AND

B. PREVENT CARRIERS THAT OFFER QUALIFIED HEALTH PLANS IN THE EXCHANGE FROM ENGAGING IN PROHIBITED DISCRIMINATORY PRACTICES IN THE FUTURE.

(III) IN THE REPORT REQUIRED ON OR BEFORE JUNE 1, 2016, THE EXCHANGE SHALL, IN ADDITION TO THE REQUIREMENTS UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH:

1. PROVIDE AN ASSESSMENT OF THE QUALIFIED HEALTH PLANS OFFERED IN THE EXCHANGE THAT ADDRESSES PLAN COMPLIANCE WITH THE BENEFIT DESIGN REQUIREMENTS OF § 31-115.1 OF THIS TITLE; AND

2. ADDRESS ANY EFFORTS THAT THE EXCHANGE PLANS TO UNDERTAKE TO ENSURE THAT A PLAN CERTIFIED AS A QUALIFIED HEALTH PLAN DOES NOT IMPERMISSIBLY DISCRIMINATE AGAINST AN ENROLLEE BY EMPLOYING A BENEFIT DESIGN THAT DENIES OR LIMITS THE PROVISION OF HEALTH CARE ON THE BASIS OF ILLNESS SEVERITY OR LIMITED LIFE EXPECTANCY, INCLUDING THROUGH THE FOLLOWING DESIGN FEATURES:

A. SPECIFIC EXCLUSION FROM COVERAGE OF NAMED THERAPIES OR CONDITIONS;

B. THE MANNER IN WHICH COVERAGE DECISIONS ARE MADE UNDER THE PLAN;

**C. DIFFERENTIAL REIMBURSEMENT RATES OR COST SHARING;**

**D. CLINICAL PREREQUISITES OR HEIGHTENED ADMINISTRATIVE REQUIREMENTS BASED ON AN ENROLLEE'S DISEASE, DISABILITY, QUALITY OR EXPECTED LENGTH OF LIFE;**

**E. INCENTIVE PROGRAMS; AND**

**F. THE USE OF AN EXCEPTIONS PROCESS THAT IS UNDULY BURDENSOME ON AN ENROLLEE OR RESULTS IN AN UNREASONABLE DELAY IN TREATMENT FOR AN ENROLLEE.**

**(IV) THE REPORTS REQUIRED IN 2017 AND EACH YEAR THEREAFTER UNDER THIS PARAGRAPH SHALL INCLUDE:**

**1. A DESCRIPTION OF ANY CHANGES MADE TO THE PROCESS UTILIZED BY THE EXCHANGE FOR REVIEWING QUALIFIED HEALTH PLAN COMPLIANCE WITH BENEFIT DESIGN REQUIREMENTS OF § 31-115.1 OF THIS TITLE; AND**

**2. THE EXTENT TO WHICH PROHIBITED DISCRIMINATORY PRACTICES HAVE BEEN IDENTIFIED, MITIGATED, AND PREVENTED BY THE EXCHANGE.**

**(V) THE REPORTS REQUIRED UNDER THIS PARAGRAPH SHALL BE MADE AVAILABLE TO THE PUBLIC ON THE WEB SITE OF THE EXCHANGE WHEN ISSUED.**

**(F) THE EXCHANGE SHALL MAKE AVAILABLE TO ENROLLEES OF QUALIFIED HEALTH PLANS AND THE PUBLIC INFORMATION ON QUALIFIED HEALTH PLAN PROVIDER NETWORKS, INCLUDING A LISTING OF NETWORK PROVIDERS BY SPECIALTY CATEGORY.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to qualified health plans issued, delivered, or renewed in the State on and after January 1, 2016.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2015.