

# SENATE BILL 834

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CF HB 990

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By: **Senators Pugh and Benson**

Introduced and read first time: February 23, 2015

Assigned to: Rules

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## A BILL ENTITLED

1 AN ACT concerning

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

3 FOR the purpose of altering certain requirements for certification as a qualified health plan  
4 in the Maryland Health Benefit Exchange; prohibiting a qualified health plan from  
5 using a benefit design or implementing a benefit design in a manner that  
6 discriminates in a certain manner; prohibiting a qualified health plan from utilizing  
7 a certain management technique except under certain circumstances; requiring  
8 certain carriers to submit to the Exchange certain information at a certain time and  
9 in a certain manner; requiring the Exchange to perform a certain evaluation on or  
10 before a certain date; prohibiting certain carriers from making certain formulary  
11 changes during a certain period with a certain exception; authorizing certain carriers  
12 to make a certain formulary change under a certain circumstance; requiring a  
13 qualified health plan formulary to be reviewed by a certain pharmacy and  
14 therapeutics committee; establishing certain membership requirements for the  
15 committee; requiring the committee to perform a certain review in a certain manner  
16 and to make recommendations regarding certain matters; authorizing the committee  
17 to perform a certain review and make certain recommendations on certain  
18 prescription drugs in a certain manner under certain circumstances; requiring  
19 meetings of the committee to occur at a certain frequency; requiring certain carriers  
20 to make certain information available to the public in a certain manner; establishing  
21 certain provider network requirements for qualified health plans; requiring the  
22 Exchange and the Maryland Insurance Commissioner to establish certain standards;  
23 requiring certain carriers to submit to the Exchange and the Commissioner certain  
24 information at a certain time and in a certain manner; requiring the Exchange and  
25 the Commissioner to review certain information to make a certain determination;  
26 requiring certain carriers to authorize the receipt of certain services from certain  
27 providers under certain circumstances; prohibiting certain carriers from requiring  
28 an enrollee to pay a certain deductible, copayment, or coinsurance amount for certain  
29 services under a certain circumstance; requiring certain essential health benefits to  
30 include a certain benefit that consists of prescription drugs that are offered in a  
31 certain manner; prohibiting a carrier from assigning a certain drug to a certain tier

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

8 BY repealing and reenacting, with amendments,

9 Article – Insurance

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

11 Annotated Code of Maryland

12 (2011 Replacement Volume and 2014 Supplement)

13 BY repealing and reenacting, without amendments,

14 Article – Insurance

15 Section 31–115(k)(1)

16 Annotated Code of Maryland

17 (2011 Replacement Volume and 2014 Supplement)

18 BY adding to

19 Article – Insurance

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

21 Annotated Code of Maryland

22 (2011 Replacement Volume and 2014 Supplement)

23 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

24 That the Laws of Maryland read as follows:

25 **Article – Insurance**

26 31–115.

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

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

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

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

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

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

6 (5) be offered by a carrier that:

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

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

11 1. at a bronze level of coverage;

12 2. at a silver level of coverage; and

13 3. at a gold level of coverage;

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

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

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

25 (vi) does not charge any cancellation fees or penalties in violation of  
26 § 31-108(d) of this title; and

27 (vii) complies with the regulations adopted by the Secretary under §  
28 1311(d) of the Affordable Care Act and by the Exchange under § 31-106(c)(1)(iv) of this  
29 title;

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

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

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

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

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

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

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

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

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

15 **[(9)] (12)** meet any other requirements established by the Exchange under  
16 this title, including:

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

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

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

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

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

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

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

5 (i) enrollment;

6 (ii) essential community providers;

7 (iii) complaints and grievances involving the Exchange;

8 (iv) network adequacy;

9 (v) quality;

10 (vi) transparency;

11 (vii) race, ethnicity, language, interpreter need, and cultural  
12 competency (RELICC);

13 (viii) plan service area, including demographics;

14 (ix) accreditation; [and]

15 (x) complying with fair marketing standards developed jointly by  
16 the Exchange and the Commissioner;

17 (XI) BENEFIT DESIGN; AND

18 (XII) FORMULARY MANAGEMENT PRACTICES.

19 **31-115.1.**

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

22 (2) "BENEFIT DESIGN" INCLUDES:

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

25 (II) THERAPIES OR CONDITIONS EXPRESSLY EXCLUDED FROM  
26 COVERAGE;

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

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

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

8 (VI) INCENTIVE PROGRAMS; AND

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

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

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

17 (II) THAT APPLIES ONLY TO:

18 1. SPECIFIED DISEASES OR CONDITIONS; OR

19 2. SUBSETS OF PATIENTS OR ENROLLEES OF A HEALTH  
20 BENEFIT PLAN.

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

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

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

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

29 (I) AGE;

- 1                   (II)    EXPECTED LENGTH OF LIFE;
- 2                   (III)   RACE;
- 3                   (IV)   COLOR;
- 4                   (V)     NATIONAL ORIGIN;
- 5                   (VI)   SEX;
- 6                   (VII)  GENDER IDENTITY;
- 7                   (VIII) SEXUAL ORIENTATION;
- 8                   (IX)   PRESENT OR PREDICTED DISABILITY;
- 9                   (X)     DEGREE OF MEDICAL DEPENDENCY;
- 10                  (XI)   QUALITY OF LIFE; OR
- 11                  (XII)  PRESENT OR PREDICTED DIAGNOSIS, DISEASE, OR HEALTH
- 12   CONDITION.

13                   (2)    A QUALIFIED HEALTH PLAN MAY NOT UTILIZE A DISCRIMINATORY

14   MEDICAL MANAGEMENT TECHNIQUE UNLESS THE TECHNIQUE IS BASED ON

15   GENERALLY ACCEPTED BEST MEDICAL PRACTICES FOR THE TREATMENT OF A

16   DISEASE, CONDITION, OR CATEGORY OF PATIENTS.

17                  (C)   (1)   EACH CARRIER THAT OFFERS A QUALIFIED HEALTH PLAN SHALL

18   SUBMIT TO THE EXCHANGE, ON AN ANNUAL BASIS AND IN THE MANNER AND FORM

19   REQUESTED BY THE EXCHANGE, INFORMATION ABOUT:

20                   (I)    THE ITEMS AND SERVICES COVERED UNDER THE QUALIFIED

21   HEALTH PLAN FOR EACH OF THE 10 ESSENTIAL HEALTH BENEFIT CATEGORIES FOR

22   WHICH COVERAGE IS REQUIRED UNDER THE AFFORDABLE CARE ACT;

23                   (II)   ANY EXCLUSIONS OR LIMITATIONS ON ITEMS OR SERVICES

24   UNDER THE QUALIFIED HEALTH PLAN;

25                   (III)  IF THE QUALIFIED HEALTH PLAN HAS A FORMULARY, THE

26   FORMULARY, INCLUDING THE TIER STRUCTURE OF THE FORMULARY, A LIST OF

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

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

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

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

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

16 31-115.2.

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

20 (1) REMOVE A PRESCRIPTION DRUG FROM A FORMULARY;

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

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

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



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

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

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

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

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

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

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

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

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

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

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

32 2. UTILIZE A TRANSPARENT PROCESS; AND

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

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

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

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

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

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

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

25 **31-115.3.**

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

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

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

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

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

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

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

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

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

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

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

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

31                   **3. URAC.**

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

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

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

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

23 31-116.

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

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

33 [(1)] (1) SUBJECT TO PARAGRAPHS (3) AND (4) OF THIS  
34 SUBSECTION, shall be the benefits in the State benchmark plan, selected in accordance  
35 with this section; [and]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 31-119.

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

13                   (2) The report shall:

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

15                           (ii) include data regarding:

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

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

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

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

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

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

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

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

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

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

11 2. ACTIONS TAKEN BY THE EXCHANGE TO:

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

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

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

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

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

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

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

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

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

6                   **E. INCENTIVE PROGRAMS; AND**

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

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

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

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

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

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

26                   SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to  
27 qualified health plans issued, delivered, or renewed in the State on and after January 1,  
28 2016.

29                   SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July  
30 1, 2015.