HB 990

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 990 (Delegate Kelly, *et al.*)
Health and Government Operations

Maryland Health Benefit Exchange - Qualified Health Plans - Standards

This bill requires that a qualified health plan (QHP), as a condition of certification, must (1) have a benefit design and be administered in a manner that does not discriminate against an individual or use discriminatory medical management techniques; (2) comply with specified prescription drug formulary management requirements; and (3) meet specified requirements relating to network adequacy. The bill also alters requirements for essential health benefits relating to prescription drug coverage.

Annually, carriers must submit specified information to the Maryland Health Benefit Exchange (MHBE) and MHBE must evaluate whether a carrier is in compliance with specified requirements. MHBE and the Insurance Commissioner must jointly establish standards for QHP network adequacy. Annually by June 1, the MHBE Board must submit a report to the Governor and the General Assembly on the process used to assess QHP carrier compliance with the benefit design requirements of the bill.

The bill takes effect July 1, 2015, and applies to QHPs issued, delivered, or renewed in the State on or after January 1, 2016.

Fiscal Summary

State Effect: Special fund expenditures increase by *at least* $896,400 in FY 2016 for personnel costs to implement the bill, including $823,900 for MHBE and $72,500 for the Maryland Insurance Administration (MIA). Future years reflect inflation and elimination of one-time start-up costs. Minimal special fund revenue increase from the $125 rate and form filing fee in FY 2016.

(in dollars)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
SF Revenue	-	$0	$0	$0	$0
SF Expenditure	$896,400	$867,600	$907,400	$949,200	$992,900
Net Effect	($896,400)	($867,600)	($907,400)	($949,200)	($992,900)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Nondiscrimination in Benefit Design and Medical Management Techniques: A QHP may not use or implement a benefit design that discriminates on the basis of an individual's age; expected length of life; race; color; national origin; sex; gender identity; sexual orientation; present or predicted disability; degree of medical dependency; quality of life; or present or predicted diagnosis, disease, or health condition. A QHP may not use a discriminatory medical management technique unless the technique is based on generally accepted best medical practices.

Carrier Reporting: Each carrier that offers a QHP must annually submit to MHBE information about (1) the items and services covered under the QHP for each of the 10 essential health benefit (EHB) categories; (2) any exclusions or limitations; (3) a list of each prescription drug on any drug formulary, the tier structure, and the tier placement of each drug on the formulary; (4) any use of a network of health care providers; and (5) cost-sharing requirements for covered items and services. This information must be submitted in a machine-readable format that enables MHBE to analyze and compare the information with information submitted for other QHPs.

Prescription Drug Formularies: During a plan year and the open enrollment period that precedes the plan year, a carrier that offers a QHP may not (1) remove a prescription drug from a formulary; (2) move a prescription drug to a benefit tier that requires an enrollee to pay greater cost sharing; or (3) add a utilization management restriction to a prescription drug in the formulary. A carrier may move a prescription drug to a benefit tier that requires greater cost sharing if, at the same time, the carrier adds to the formulary an AB-rated generic drug for the prescription drug.

Pharmacy and Therapeutics Committee: A QHP formulary must be reviewed by an independent pharmacy and therapeutics (P&T) committee that meets specified criteria. A P&T committee must (1) review and make recommendations regarding the safety and

efficacy of prescription drugs included or proposed for inclusion in a formulary and whether formulary management practices utilized by a QHP are clinically appropriate and consistent with industry standards and guidelines; (2) base its recommendations on the strength of scientific evidence, standards of practice, and nationally accepted treatment guidelines; (3) utilize a transparent process; and (4) document its recommendations in writing. A P&T committee must review and make a formulary recommendation on a drug that is newly approved by the U.S. Food and Drug Administration within 90 days after the approval of the drug. Such action may take place more than 90 days after the approval of the drug if the P&T committee provides a clinical justification for the delay. A P&T committee must meet at least quarterly.

A carrier that offers a QHP must make available on the carrier's website recommendations made by the P&T committee relating to the QHP formulary, management of the formulary, and other utilization management practices of the QHP as well as the meeting minutes of the P&T committee.

Network Adequacy: A QHP must 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. MHBE must make information on QHP provider networks available to QHP enrollees and the public.

A carrier must annually submit to MHBE and the Insurance Commissioner information about the network of each QHP and actions taken by the carrier to ensure network adequacy. MHBE and the Insurance Commissioner must review the information to determine whether a QHP network is adequate.

If a QHP network changes during a plan year and no longer meets network adequacy standards, a carrier must authorize the receipt of covered services by enrollees from out-of-network (OON) providers. A carrier may not require an enrollee to pay greater cost sharing for services provided by an OON provider than would be required for the same service from an in-network provider.

Alterations to Essential Health Benefits: EHBs for prescription drugs must be *offered in a specified manner*. For a QHP with a drug formulary, a carrier may not assign a prescription drug to a nonpreferred formulary tier unless the 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.

If a QHP requires an enrollee to pay a deductible for the plan's prescription drug benefit, the deductible must be separate from any deductible that applies to another benefit under

the QHP. The dollar amount of the deductible may not exceed 10% of the dollar amount of any other deductible that applies to another benefit under the QHP for medical items and services. These requirements do not apply to a catastrophic plan or a health benefit plan that provides a bronze level of coverage.

Current Law: To be certified as a QHP, a health benefit plan must (1) provide EHBs required under the federal Patient Protection and Affordable Care Act (ACA); (2) obtain prior approval of premium rates and contract language from the Commissioner; (3) provide at least a bronze level of coverage; (4) ensure that cost-sharing requirements do not exceed the limits specified under ACA; (5) be offered by a carrier that is licensed and in good standing to offer health insurance in Maryland and meets other specified criteria; (6) meet the requirements for certification established under regulations; (7) be in the interest of qualified individuals and qualified employers as determined by MHBE; (8) provide any other benefits required by the Insurance Commissioner under State law or regulation; and (9) meet any other requirements established by MHBE.

Subject to hearing provisions, MHBE may deny certification to a health benefit plan or suspend or revoke the certification of a QHP based on a finding that the plan does not satisfy requirements or has otherwise violated specified standards for certification. Certification requirements must include providing data and meeting standards relating to enrollment; essential community providers; complaints and grievances involving MHBE; network adequacy; quality; transparency; race, ethnicity, language, interpreter need, and cultural competency; plan service area; accreditation; and complying with fair marketing standards. Instead of or in addition to denying, suspending, or revoking certification, MHBE may take corrective action to remedy a violation of or failure to comply with standards for certification and impose a penalty of up to $5,000 for each violation of or failure to comply with standards for certification. These penalties must be in addition to any criminal or civil penalties imposed for fraud or other violations.

ACA requires nongrandfathered health plans to cover 10 EHBs, which include items and services in the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision care. Under § 31-116 of the Maryland Insurance Article, these EHBs must be included in the State benchmark plan and required in all QHPs offered in MHBE and all individual health benefit plans and health benefit plans offered to small employers outside of MHBE (with the exception of grandfathered health plans).

Section 1557 of ACA applies existing federal civil rights protections to private health insurance and prohibits individuals from being subject to discrimination, excluded from

participation, or denied the benefits of health programs or activities based on race, color, national origin, sex, age, or disability. These requirements are enforced by the Office of Civil Rights within the U.S. Department of Health and Human Services (HHS) and apply broadly to include the exchanges in every state.

Several revisions to federal regulations regarding QHP standards were published on February 27, 2015. Prohibition on discrimination regulations (45 CFR § 156.125) specify that a carrier does not provide EHBs if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. A carrier must also comply with certain participation standards (45 CFR § 156.200), which, among other things, prohibit a QHP from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Prescription drug benefit regulations (45 CFR § 156.122) require a health benefit plan, *for plan years beginning on or after January 1, 2017*, to use a P&T committee that meets specified standards that are less stringent than those proposed under the bill.

Network adequacy standard regulations (45 CFR § 156.230) require a carrier to ensure that the provider network of each QHP (1) includes essential community providers; (2) is sufficient in number and types of providers (including mental health and substance abuse) to assure that all services will be accessible without unreasonable delay; and (3) is consistent with the network adequacy standards of the federal Public Health Services Act. A QHP must make its provider directory available to a state exchange for publication online and to potential enrollees in hard copy upon request. The directory must identify providers that are not accepting new patients.

Background: The primary function of MHBE is to certify and make available QHPs and qualified dental plans to individuals and businesses and serve as a gateway to an expanded Medicaid program under ACA. As of February 15, 2015, 111,096 Marylanders had enrolled in a QHP during the second open enrollment period (November 15, 2014, through February 15, 2015). During the 2013-2014 open enrollment period (October 1, 2013, through March 31, 2014), a total of 81,091 individuals enrolled in a QHP.

According to MHBE, the process by which carriers certify QHPs works as follows. Carriers submit their proposed benefit designs and rates to the Maryland Insurance Administration (MIA) using federal templates through the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (better known as SERFF) system annually by May 1 (this date may vary based on the dates for open enrollment designated by HHS). MIA reviews the proposals and approves, disapproves, or requests modification of submissions, typically by August 30.

MHBE downloads the approved benefit design and rate information for QHPs into its own system and then certifies carriers to participate in the exchange using basic measures such as financial sufficiency and carrier attestation to network adequacy.

State Expenditures: MHBE advises that the current three certification and compliance staff are unable to absorb the significant additional workload under the bill. Thus, special fund expenditures for MHBE increase by *a minimum of* $823,933 in fiscal 2016, which accounts for the bill's July 1, 2015 effective date. This estimate reflects the cost of hiring 10 full-time positions, including 4 benefit design analysts to review and evaluate benefit design for QHPs to determine compliance with State and federal nondiscrimination provisions; 1 clinical nurse specialist to staff/monitor the P&T committee and ensure carrier compliance with P&T committee requirements; 2 actuarial accountants and 1 prescription drug manager to review prescription drug formularies, tiers, and deductibles in order to determine compliance with formulary management requirements; at least 1 network adequacy analyst to work with MIA to establish standards for QHP network adequacy and to receive and review annual network adequacy reports that will be submitted to both MHBE and MIA; and at least 1 compliance analyst to prepare and comply with the bill's reporting requirements. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	10
Salaries and Fringe Benefits	$753,233
One-time Start-up Expenses	42,850
Ongoing Operating Expenses	27,850
Total FY 2016 MHBE Expenditures	**$823,933**

In addition to personnel costs, MHBE could incur additional expenditures to meet the requirement to make information available on QHP provider networks, including a listing of network providers by specialty category. MHBE currently contracts with an information technology company that hosts and maintains QHP provider directories. To the extent this system must be changed, special fund expenditures increase by a potentially significant amount, which is not included in the estimate above.

Future year expenditures reflect annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Special fund expenditures for MIA increase by *a minimum of* $72,507 in fiscal 2016, which accounts for the bill's July 1, 2015 effective date. This estimate reflects the cost of hiring at least one additional analyst to work with MHBE to establish standards for QHP network adequacy and to receive and review annual network adequacy reports that will be submitted to both MHBE and MIA. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1
Salary and Fringe Benefits	$65,437
One-time Start-up Expenses	4,285
Ongoing Operating Expenses	2,785
Total FY 2016 MIA Expenditures	**$72,507**

Future year expenditures reflect annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Additional Comments: In November 2014, NAIC released a draft updating its Managed Care Network Adequacy Model Act. Because of NAIC's ongoing efforts to update this model law, HHS stated that it is waiting on the final model act before enacting additional federal regulatory changes to network adequacy policies for products offered in state exchanges in 2016.

Additional Information

Prior Introductions: None.

Cross File: SB 834 (Senators Pugh and Benson) - Finance.

Information Source(s): Center on Health Insurance Reforms, Georgetown University Health Policy Institute; Department of Health and Mental Hygiene; Maryland Insurance Administration; Maryland Health Benefit Exchange; Department of Legislative Services

Fiscal Note History: First Reader - March 11, 2015
md/ljm

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510