HOUSE BILL 92

Unofficial Copy 2000 Regular Session
C3 (0lr0150)

ENROLLED BILL
-- Economic Matters/Finance --

Introduced by **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____
Speaker.

CHAPTER 331

AN ACT concerning

Health Insurance - Risk Based Capital Standards for Insurers <u>and Managed Care Organizations</u>

FOR the purpose of requiring certain insurers to meet certain risk based capital standards; requiring the Insurance Commissioner to take certain action against certain insurers under certain circumstances; altering certain terms; defining certain terms; <u>requiring the Insurance Commissioner, *in consultation with the Secretary of Health and Mental Hygiene*, to adopt regulations that apply risk based capital standards to certain managed care organizations by a certain date; requiring certain managed care organizations to comply with certain risk based capital standards; making technical changes;</u> and generally relating to risk based capital standards for insurers <u>and managed care organizations</u>.

BY renumbering
Article - Health - General
Section 19-710(e) through (s), respectively

to be Section 19-710(f) through (t), respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-102.4
Annotated Code of Maryland
(1994 Replacement Volume and 1999 Supplement)

BY adding to
Article - Health - General
Section 19-710(e)
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 4-301, 4-304, 4-308, and 4-311
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19-710(e) through (s), respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 19-710(f) through (t), respectively.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

15-102.4.

(a) (1) Each managed care organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this section, the surplus that a managed care organization is required to have shall be paid in full.

(ii) A managed care organization shall have an initial surplus that exceeds the liabilities of the managed care organization by at least $1,500,000.

(b) (1) In consultation with the Secretary, the Insurance Commissioner may adjust the initial surplus requirement for a managed care organization that is not licensed as a health maintenance organization. In determining whether to make an adjustment under [paragraph (1) of this subsection] THIS PARAGRAPH, the Commissioner shall consider:

(i) The proposed capitation level that would be received by the managed care organization under a contract with the Department under this subtitle;

(ii) The proposed range of benefits to be provided under a contract with the Department under this subtitle;

(iii) The existence of any commitment by the Secretary to designate funds over and above the proposed capitation where the designated funds:

1. Are equivalent to the difference between the requirements of § 19-710 of this [subtitle] ARTICLE and any lower requirements determined by the Commissioner under this subparagraph; and

2. Would be available in case of the impairment or insolvency of the managed care organization; and

(iv) The availability of the money held in trust by the Secretary to pay claims in case of impairment or insolvency of the managed care organization.

(2) Notwithstanding subsection (a)(2)(ii) of this section, a managed care organization shall have an initial surplus that exceeds liabilities by at least $1,250,000. If a managed care organization has an initial surplus that is at least $1,250,000 but less than $1,500,000, prior to approval, the Department shall designate funds under paragraph (1)(iii) of this subsection sufficient to provide an initial surplus of at least $1,500,000.

(c) (1) (i) Each managed care organization shall maintain a surplus that exceeds the liabilities of the managed care organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the managed care organization with the Commissioner.

(ii) No managed care organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(2) (i) For the protection of the managed care organization's enrollees and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5-701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with the provisions of Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a managed care organization shall be treated as an insurer.

(D) EACH MANAGED CARE ORGANIZATION SHALL COMPLY WITH RISK BASED CAPITAL STANDARDS IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE INSURANCE COMMISSIONER UNDER § 4-311 OF THE INSURANCE ARTICLE.

[(d)] (E) On or before June 1 of each year, the Secretary shall submit to the General Assembly, in accordance with § 2-1246 of the State Government Article, a report on:

(1) The number of managed care organizations for which the Secretary has designated money to be held in trust under this [subsection] SECTION; and

(2) The amount of money held in trust by the Secretary that has been paid out in cases of insolvency or impairment of managed care organizations.

19-710.

(E) THE PROVISIONS OF TITLE 4, SUBTITLE 3 OF THE INSURANCE ARTICLE (RISK BASED CAPITAL STANDARDS FOR INSURERS) APPLY TO HEALTH MAINTENANCE ORGANIZATIONS IN THE SAME MANNER AS THEY APPLY TO INSURERS.

Article - Insurance

4-301.

(a) In this subtitle the following words have the meanings indicated.

(b) "Adjusted RBC report" means an RBC report that has been adjusted by the Commissioner in accordance with § 4-303(b) of this subtitle.

(c) "Corrective order" means an order issued by the Commissioner that specifies corrective actions that the Commissioner has determined are required.

(d) (1) "Domestic insurer" [has the meaning stated in § 1-101(o) of this article.] MEANS AN INSURER:

(I) AS DEFINED IN SUBSECTION (H) OF THIS SECTION; AND

(II) THAT IS FORMED UNDER THE LAWS OF THIS STATE.

(2) "Domestic insurer" does not include the Maryland Automobile Insurance Fund.

(e) "Filing date" means March 1 of any given year.

(f) "Foreign insurer" [has the meaning stated in § 1-101(p) of this article.] MEANS AN INSURER:

(1) AS DEFINED IN SUBSECTION (H) OF THIS SECTION; AND

(2) THAT IS FORMED UNDER THE LAWS OF A JURISDICTION OTHER THAN THIS STATE.

(G) (1) "HEALTH INSURER" MEANS AN INSURER THAT:

(I) IS AUTHORIZED TO WRITE HEALTH INSURANCE IN THE STATE; AND

(II) RECEIVES THE MAJORITY OF ITS PREMIUM FROM THE SALE OF HEALTH INSURANCE.

(2) "HEALTH INSURER" INCLUDES:

(I) A HEALTH MAINTENANCE ORGANIZATION OPERATING UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE;

(II) A NONPROFIT HEALTH SERVICE PLAN OPERATING UNDER TITLE 14, SUBTITLE 1 OF THIS ARTICLE;

(III) A DENTAL PLAN OPERATING UNDER TITLE 14, SUBTITLE 4 OF THIS ARTICLE; AND

(IV) A PROVIDER-SPONSORED ORGANIZATION OPERATING UNDER TITLE 19, SUBTITLE 7A OF THE HEALTH - GENERAL ARTICLE.

(3) "HEALTH INSURER" DOES NOT INCLUDE A MANAGED CARE ORGANIZATION OPERATING UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

(H) (1) "INSURER" MEANS AN INSURER OR OTHER ENTITY AUTHORIZED TO ENGAGE IN THE INSURANCE BUSINESS IN THE STATE UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER.

(2) "INSURER" INCLUDES:

(I) A HEALTH MAINTENANCE ORGANIZATION OPERATING UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE;

(II) A NONPROFIT HEALTH SERVICE PLAN OPERATING UNDER TITLE 14, SUBTITLE 1 OF THIS ARTICLE;

(III) A DENTAL PLAN OPERATING UNDER TITLE 14, SUBTITLE 4 OF THIS ARTICLE; AND

(IV) A PROVIDER-SPONSORED ORGANIZATION OPERATING UNDER TITLE 19, SUBTITLE 7A OF THE HEALTH - GENERAL ARTICLE.

(3) "INSURER" DOES NOT INCLUDE:

(I) MONOLINE:

1. MORTGAGE GUARANTY INSURERS;

2. FINANCIAL GUARANTY INSURERS; OR

3. TITLE INSURERS; OR

(II) MANAGED CARE ORGANIZATIONS OPERATING UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

[(g)] (I) "Life insurer" means[:

(1)] an insurer THAT:

(1) IS authorized to write life insurance in the State [that is also authorized to write health insurance in the State;

(2) an insurer authorized to write life insurance in the State; or

(3) a property and casualty insurer that writes only accident and health insurance]; AND

(2) RECEIVES THE MAJORITY OF ITS PREMIUM FROM THE SALE OF LIFE INSURANCE.

[(h)] (J) "NAIC" means the National Association of Insurance Commissioners.

[(i) (1) "Property and casualty insurer" means an insurer authorized to write property insurance or casualty insurance in the State.

(2) "Property and casualty insurer" does not include monoline:

(i) mortgage guaranty insurers;

(ii) financial guaranty insurers; or

(iii) title insurers.]

(K) (1) "PROPERTY AND CASUALTY INSURER" MEANS AN INSURER THAT:

(I) IS AUTHORIZED TO WRITE PROPERTY INSURANCE OR CASUALTY INSURANCE IN THE STATE; AND

(II) RECEIVES THE MAJORITY OF ITS PREMIUM FROM THE SALE OF PROPERTY INSURANCE OR CASUALTY INSURANCE.

(2) "PROPERTY AND CASUALTY INSURER" DOES NOT INCLUDE:

(I) A HEALTH MAINTENANCE ORGANIZATION OPERATING UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE;

(II) A NONPROFIT HEALTH SERVICE PLAN OPERATING UNDER TITLE 14, SUBTITLE 1 OF THIS ARTICLE;

(III) A DENTAL PLAN OPERATING UNDER TITLE 14, SUBTITLE 4 OF THIS ARTICLE;

(IV) A PROVIDER-SPONSORED ORGANIZATION OPERATING UNDER TITLE 19, SUBTITLE 7A OF THE HEALTH - GENERAL ARTICLE; OR

(V) A MANAGED CARE ORGANIZATION OPERATING UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

[(j)] (L) "Negative trend" means, with respect to a life insurer or health insurer, negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions.

[(k)] (M) "RBC instructions" means the risk based capital instructions developed and adopted by the NAIC.

[(l)] (N) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC if:

(1) "company action level RBC" means the product of 2.0 and the authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and the authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk based capital formula in accordance with the RBC instructions; or

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

[(m)] (O) "RBC plan" means a comprehensive financial plan that contains the elements specified in § 4-305(b) of this subtitle.

[(n)] (P) "RBC report" means a report prepared by a domestic insurer and submitted to the Commissioner that details the domestic insurer's RBC levels as of the end of the immediately preceding calendar year.

[(o)] (Q) "Revised RBC plan" means an RBC plan that has been:

(1) rejected by the Commissioner; and

(2) subsequently revised by the insurer, with or without the Commissioner's recommendation.

[(p)] (R) "Total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus as determined in accordance with the statutory accounting principles applicable to the annual financial statements required to be filed under [this article] STATE LAW AND REGULATIONS; and

(2) any other items provided for in the RBC instructions.

4-304.

(a) (1) A life insurer's risk based capital shall be determined in accordance with the formula set forth in the RBC instructions.

(2) By applying the factors in the manner set forth in the RBC instructions, the formula shall take into account and may adjust for the covariance between:

(i) the risk with respect to the life insurer's assets;

(ii) the risk of adverse insurance experience with respect to the life insurer's liabilities and obligations;

(iii) the interest rate risk with respect to the life insurer's business; and

(iv) all other business risks and other relevant risks as set forth in the RBC instructions.

(b) (1) [A property and casualty] EXCEPT AS PROVIDED IN SUBSECTION (A) OF THIS SECTION, AN insurer's risk based capital shall be determined in accordance with the formula set forth in the RBC instructions.

(2) By applying the factors in the manner set forth in the RBC instructions, the formula shall take into account and may adjust for the covariance between:

(i) asset risk;

(ii) credit risk;

(iii) underwriting risk; and

(iv) all other business risks and other relevant risks as set forth in the RBC instructions.

4-308.

(a) A mandatory control level event occurs when:

(1) an insurer files an RBC report that indicates that the insurer has total adjusted capital that is less than its mandatory control level RBC;

(2) the Commissioner notifies the insurer of an adjusted RBC report that indicates an event under item (1) of this subsection; or

(3) if an insurer requests a hearing to challenge an adjusted RBC report that indicates the event under item (1) of this subsection, the Commissioner notifies

the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(b) (1) In the case of a life insurer, if a mandatory control level event occurs with respect to the life insurer, the Commissioner shall take any action that may be necessary to place the life insurer under conservation, rehabilitation, or liquidation under Title 9 of this article.

(2) In the case of a property and casualty insurer, if a mandatory control level event occurs with respect to the property and casualty insurer, the Commissioner:

(i) shall take any action that may be necessary to place the property and casualty insurer under conservation, rehabilitation, or liquidation under Title 9 of this article; or

(ii) in the case of a property and casualty insurer that is not writing any new business and that is running off its existing business, may allow the property and casualty insurer to continue its run-off under the supervision of the Commissioner.

(3) ~~(I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH,~~ IN THE CASE OF A HEALTH INSURER, IF A MANDATORY CONTROL LEVEL EVENT OCCURS WITH RESPECT TO THE HEALTH INSURER, THE COMMISSIONER SHALL TAKE ANY ACTION THAT MAY BE NECESSARY TO PLACE THE HEALTH INSURER UNDER CONSERVATION, REHABILITATION, OR LIQUIDATION UNDER TITLE 9 OF THIS ARTICLE.

~~(II) IN THE CASE OF A HEALTH MAINTENANCE ORGANIZATION, IF A MANDATORY CONTROL LEVEL EVENT OCCURS WITH RESPECT TO THE HEALTH MAINTENANCE ORGANIZATION, THE COMMISSIONER SHALL TAKE ACTION UNDER TITLE 19 OF THE HEALTH - GENERAL ARTICLE.~~

(c) The Commissioner may delay action under subsection (b) of this section for up to 90 days after the occurrence of the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(d) (1) The Commissioner shall have the rights, powers, and duties under Title 9 of this article needed to carry out the requirements of this section.

(2) If the Commissioner takes any action under Title 9 of this article pursuant to an adjusted RBC report as provided in this section, the insurer shall be entitled to the protections afforded to insurers under Title 9 of this article with regard to summary proceedings.

4-311.

(a) The provisions of this Act are supplemental to other laws of the State, and may not preclude or limit any other powers or duties of the Commissioner ~~[under this~~

~~article], including Title 9 of this article AND TITLE 19 OF THE HEALTH - GENERAL ARTICLE~~.

(b) (1) The Commissioner may adopt regulations to carry out this subtitle.

(2) THE COMMISSIONER, *IN CONSULTATION WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE*, SHALL ADOPT REGULATIONS THAT APPLY APPROPRIATE RISK BASED CAPITAL STANDARDS TO MANAGED CARE ORGANIZATIONS AS DEFINED UNDER § 15-101(F) OF THE HEALTH - GENERAL ARTICLE.

(c) The Commissioner may exempt from the application of this Act any domestic property and casualty insurer that:

(1) writes direct business only in the State;

(2) writes direct annual premiums of $2,000,000 or less; and

(3) assumes no reinsurance in excess of 5% of direct premiums written.

SECTION 3. AND BE IT FURTHER ENACTED, That the Insurance Commissioner, *in consultation with the Secretary of Health and Mental Hygiene*, shall adopt regulations that apply risk based capital standards to managed care organizations no later than July 1, 2001.

SECTION ~~3.~~ 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000.