Article - Insurance

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§15–605.

(a) (1) On or before March 1 of each year, an annual report that meets the specifications of paragraph (2) of this subsection shall be submitted to the Commissioner by:

(i) each authorized insurer that provides health insurance in the State;

(ii) each nonprofit health service plan that is authorized by the Commissioner to operate in the State;

(iii) each health maintenance organization that is authorized by the Commissioner to operate in the State; and

(iv) as applicable in accordance with regulations adopted by the Commissioner, each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health – General Article.

(2) The annual report required under this subsection shall:

(i) be submitted in a form required by the Commissioner; and

(ii) include for the preceding calendar year the following data for all health benefit plans specific to the State:

1. premiums written;

2. premiums earned;

3. total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

4. total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, estimated if necessary;

5. loss ratio; and

6. expense ratio.

(3) The data required under paragraph (2) of this subsection shall be reported:

(i) by product delivery system for health benefit plans that are issued under Subtitle 12 of this title;

(ii) in the aggregate for health benefit plans that are issued to individuals;

(iii) in the aggregate for a managed care organization that operates under Title 15, Subtitle 1 of the Health – General Article; and

(iv) in a manner determined by the Commissioner in accordance with this subsection for all other health benefit plans.

(4) The Commissioner, in consultation with the Secretary of Health and Mental Hygiene, shall establish and adopt by regulation a methodology to be used in the annual report that ensures a clear separation of all medical and administrative expenses whether incurred directly or through a subcontractor.

(5) The Commissioner may conduct an examination to ensure that an annual report submitted under this subsection is accurate.

(6) Failure of an insurer, nonprofit health service plan, or health maintenance organization to submit the information required under this subsection in a timely manner shall result in a penalty of $500 for each day after March 1 that the information is not submitted.

(b) (1) Before a managed care organization may enroll a medical assistance program recipient, the managed care organization shall provide a business plan to the Commissioner.

(2) As part of the annual report required under subsection (a) of this section, a managed care organization shall:

(i) provide a list of the total compensation from the managed care organization, including all cash and deferred compensation, stock, and stock options in addition to salary, of each member of the board of directors of the managed care organization, and each senior officer of the managed care organization or any subsidiary of the managed care organization as designated by the Commissioner; and

(ii) provide any other information or documents necessary for the Commissioner to ensure compliance with this subsection and subsections (a)(3)(iii) and (c)(5), (6), and (7) of this section and for the Secretary of Health and Mental Hygiene to carry out Title 15, Subtitle 1 of the Health – General Article.

(c) (1) (i) Individual health insurance coverage and health insurance coverage offered in the small group and large group markets, as those terms are defined in the federal Public Health Service Act, issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization shall comply with the loss ratio requirements of sections 1001(5) and 10101(f) of the Affordable Care Act, which amend section 2718 of the Public Health Service Act.

(ii) The provisions of subparagraph (i) of this paragraph do not apply

to coverage for excepted benefits, as defined in 45 C.F.R. § 146.145(c).

(iii) The Commissioner may require an insurer, a nonprofit health service plan, or a health maintenance organization to file new rates if the loss ratio reported in the manner required under 45 C.F.R. § 158 is less than that required under subparagraph (i) of this paragraph.

(2) The authority of the Commissioner under paragraph (1) of this subsection to require an insurer, nonprofit health service plan, or health maintenance organization to file new rates based on loss ratio:

(i) is in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory; and

(ii) does not limit any existing authority of the Commissioner to determine whether a rate is excessive.

(3) (i) In determining whether to require an insurer to file new rates under this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer.

(ii) The insurer shall provide to the Commissioner the information necessary to determine the proportion of individual health insurance premiums to total health insurance premiums as provided under this paragraph.

(4) The Secretary of Health and Mental Hygiene, in consultation with the Commissioner and in accordance with their memorandum of understanding, may adjust capitation payments for a managed care organization or for the Maryland Medical Assistance Program of a managed care organization that is a certified health maintenance organization if the loss ratio is less than 85%.

(5) A loss ratio reported under paragraph (4) of this subsection shall be calculated separately and may not be part of another loss ratio reported under this section.

(6) Any rebate received by a managed care organization may not be considered part of the loss ratio of the managed care organization.

(7) If the Secretary of Health and Mental Hygiene adjusts capitation payments for a managed care organization or a certified health maintenance organization under paragraph (4) of this subsection, the managed care organization or certified health maintenance organization may:

(i) appeal the decision of the Secretary to the Board of Review established under Title 2, Subtitle 2 of the Health – General Article; and

(ii) take any further appeal allowed by the Administrative Procedure Act under Title 10, Subtitle 2 of the State Government Article.

(8) The Secretary of Health and Mental Hygiene shall publish in a conspicuous manner on the Web site of the Department of Health and Mental Hygiene:

(i) the loss ratio, as determined by the Department of Health and Mental Hygiene for each managed care organization participating in the medical assistance program, for each year during the most recent 3–year period;

(ii) for each year during the 3–year period, the amount to be returned to the medical assistance program, if any, from a managed care organization for failing to meet the loss ratio requirement under paragraph (4) of this subsection; and

(iii) any amount due to or received by the Department of Health and Mental Hygiene from a managed care organization for each year during the 3–year period.

(d) Each insurer, nonprofit health service plan, and health maintenance organization shall provide annually to each contract holder a written statement of the loss ratio for a health benefit plan as submitted to the Commissioner under this section.

(e) (1) (i) On or before March 1 of each year, unless, for good cause shown, the Commissioner extends the time for a reasonable period, each managed care organization shall file with the Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.

(ii) At any time, the Commissioner may require a managed care organization to file an interim statement containing the information that the Commissioner considers necessary.

(iii) The annual and interim reports shall be filed in a form required by the Commissioner.

(2) (i) Except as provided in paragraph (3) of this subsection on or before June 1 of each year, each managed care organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(ii) The audited financial report shall:

1. be filed in a form required by the Commissioner; and

2. be certified by an audit of an independent certified public accountant.

(3) With 90 days' advance notice, the Commissioner may require a managed care organization to file an audited financial report earlier than the date specified in paragraph (2) of this subsection.

(f) Each financial report filed under this section is a public record.

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