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(PRE-FILED)

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By: Delegates Busch, Taylor, Cummings, Hurson, Guns, Hixson, Rawlings, and Vallario
Requested: November 15, 1995
Introduced and read first time: January 10, 1996
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Health Insurance - Expense and Loss Ratio Information

FOR the purpose of repealing the benchmarks that provide expense ratio guidelines by which the Insurance Commissioner may require new rate filings on a health benefit plan offered by a nonprofit health service plan, insurer, or health maintenance organization; establishing certain loss ratio benchmarks; authorizing the Insurance Commissioner to collect specified information by line of business for health benefit plans in the State; imposing a penalty for failure to file information with the Commissioner in a timely manner; authorizing the Commissioner to conduct certain examinations; and requiring the Commissioner to transmit certain information to the Health Care Access and Cost Commission by a certain date.

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 490S
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

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

Article 48A - Insurance Code

490S.

(a) All authorized insurers, including nonprofit health service plans and fraternal benefit societies, shall pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission.

(b) (1) On or before March 1 of each year, each insurer that holds acertificate of authority in the State and provides health insurance in the State, each health maintenance organization that is licensed to operate in the State, and each nonprofit health service plan that is licensed to operate in the State shall submit an annual report in a form required by the Commissioner that includes, for the precedingcalendar year, the following data [in the aggregate] BY LINE OF BUSINESS for all health benefit plans specific to this State:

(i) Premiums written;

(ii) Premiums earned;

(iii) Total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

(iv) Total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, using estimates when necessary;

(v) Loss ratio; and

(vi) Expense ratio.

(2) [(i) If the loss ratio of an insurer, other than an insurerthat provides health insurance exclusively to individuals, or health maintenance organization is less than 75 percent or if its expense ratio is more than 20 percent, the Commissioner may require the insurer or health maintenance organization to file new rates for its health benefit plans.

(ii) If the loss ratio of a nonprofit health service plan is less than 75 percent or if the expense ratio of a nonprofit health service plan is more than 18 percent, the Commissioner may require the nonprofit health service plan to file new rates for its health benefit plans]

(I) IF THE LOSS RATIO IS LESS THAN 75 PERCENT FOR A HEALTH BENEFIT PLAN THAT IS ISSUED UNDER SUBTITLE 55 OF THIS ARTICLE, THE COMMISSIONER MAY REQUIRE THE NONPROFIT HEALTH SERVICE PLAN, INSURER, OR HEALTH MAINTENANCE ORGANIZATION THAT ISSUES THE HEALTH BENEFIT PLAN TO FILE NEW RATES.

(II) IN THE CASE OF A HEALTH BENEFIT PLAN ISSUED TO INDIVIDUALS, IF THE LOSS RATIO IS LESS THAN 60 PERCENT FOR A NONPROFIT HEALTH SERVICE PLAN OR LESS THAN 50 PERCENT FOR AN INSURER OR HEALTH MAINTENANCE ORGANIZATION, THE COMMISSIONER MAY REQUIRE THE NONPROFIT HEALTH SERVICE PLAN, INSURER, OR HEALTH MAINTENANCE ORGANIZATION TO FILE NEW RATES.

(iii) The authority of the Commissioner UNDER THIS PARAGRAPH to require [an insurer] A NONPROFIT HEALTH SERVICE PLAN, INSURER, OR HEALTH MAINTENANCE ORGANIZATION to file new rates based on [the insurer's] loss ratio [under this paragraph] shall be deemed to be in addition to any other authority of the Commissioner under this article to require that rates not be excessive,inadequate, or unfairly discriminatory and may not be construed to limit any existing authority of the Commissioner to determine whether a rate is excessive.

(3) In determining whether to require an insurer to file new rates under paragraph (2) of 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. The insurer shall provide

to the Commissioner the information necessary to make a determination of the proportion of individual premiums to total premiums as provided under this paragraph.

(4) FAILURE BY AN INSURER, HEALTH MAINTENANCE ORGANIZATION, OR NONPROFIT HEALTH SERVICE PLAN TO FILE THE INFORMATION REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN A TIMELY MANNER SHALL RESULT IN A PENALTY OF $500 FOR EACH DAY AFTER MARCH 1 THAT THE INFORMATION IS NOT FILED.

(5) THE COMMISSIONER MAY EXAMINE EACH COMPANY TO ENSURE THAT THE FILING REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IS ACCURATE.

(C) ON OR BEFORE MAY 1 OF EACH YEAR, THE COMMISSIONER SHALL TRANSMIT TO THE HEALTH CARE ACCESS AND COST COMMISSION ANY INFORMATION IT NEEDS TO EVALUATE BENEFITS AND COST SHARING ARRANGEMENTS IN THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN AS REQUIRED UNDER § 700 OF THIS ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1996.