SENATE BILL 351

Unofficial Copy 2003 Regular Session
C3 3lr1512
HB 1112/02 - ECM

By: **Senators Teitelbaum and Grosfeld**
Introduced and read first time: January 31, 2003
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Managed Behavioral Health Care Organizations - Expense and Loss Ratios and Reports

FOR the purpose of requiring certain carriers to submit a certain annual report that meets certain specifications; requiring the Maryland Insurance Commissioner to establish a certain methodology by regulation; requiring certain managed behavioral health care organizations and certain carriers that are required to file a certain annual report to perform an audit of certain data in the report; requiring a certain fine to be imposed on certain carriers that fail to file a certain report; requiring certain carriers to provide information contained in a certain annual report to members, prospective members, and the general public; requiring the Commissioner to make certain reports publicly available; defining certain terms; and generally relating to certain managed behavioral health care organizations and certain carriers.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-127
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 15-605
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

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

Article - Insurance

15-127.

(a) (1) In this section the following words have the meanings indicated.

(2) "BEHAVIORAL HEALTH CARE ADMINISTRATIVE EXPENSES" MEANS ANY EXPENSES THAT ARE NOT INCURRED FOR DIRECT CARE EXPENSES INCLUDING THE FOLLOWING EXPENSES FOR ADMINISTRATIVE FUNCTIONS:

(I) BILLING AND COLLECTION EXPENSES;

(II) ACCOUNTING AND FINANCIAL REPORTING EXPENSES;

(III) QUALITY ASSURANCE AND UTILIZATION MANAGEMENT PROGRAM OR ACTIVITY EXPENSES;

(IV) PROMOTION AND MARKETING EXPENSES;

(V) TAXES, FEES, AND ASSESSMENTS;

(VI) LEGAL EXPENSES;

(VII) SALARY EXPENSES FOR EMPLOYEES THAT ARE NOT RELATED TO THE DELIVERY OF DIRECT CARE EXPENSES TO PATIENTS;

(VIII) COMPUTER EXPENSES;

(IX) PROVIDER CREDENTIALING;

(X) COLLECTION AND REVIEW OF TREATMENT PLANS;

(XI) AUDITING THE FINANCIAL REPORT SUBMITTED TO THE COMMISSIONER UNDER THIS SECTION;

(XII) QUALITY ASSURANCE, STANDARDS OF CARE, OR UTILIZATION MANAGEMENT PROGRAM OR ACTIVITY EXPENSES;

(XIII) DEBT PAYMENT AND DEBT SERVICE; AND

(XIV) OTHER GENERAL AND ADMINISTRATIVE EXPENSES.

(3) "BEHAVIORAL HEALTH CARE LOSS RATIO" MEANS THE TOTAL INCURRED DIRECT BEHAVIORAL HEALTH CARE EXPENSES DIVIDED BY THE REVENUE FROM PREMIUMS AND RELATED REVENUE, EXPRESSED AS BOTH A DOLLAR FIGURE AND AS A PERCENTAGE.

[(2)] (4) "Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, drug abuse, or alcohol abuse.

[(3)] (5) "Carrier" means:

(i) a health insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a preferred provider organization;

(v) a third party administrator; [or]

(vi) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health - General Article, any other person that provides health benefit plans subject to regulation by the State; OR

(VII) ANY SUBSIDIARY OR AFFILIATED ENTITY OF A PERSON LISTED IN ITEMS (I) THROUGH (VI) OF THIS PARAGRAPH.

[(4)] (6) "Direct BEHAVIORAL HEALTH care expenses" means [the] ANY payment to a BEHAVIORAL health care provider by a managed behavioral health care organization for the provision of DIRECT behavioral health care services to a member INCLUDING:

(I) ALL DIRECT CLINICAL SERVICES TO A PATIENT PERFORMED BY A BEHAVIORAL HEALTH CARE PROVIDER; AND

(II) 50% OF SERVICES PROVIDED BY A MANAGED BEHAVIORAL HEALTH CARE ORGANIZATION FOR CRISIS SCREENING AND REFERRAL SERVICES.

[(5) "Direct payments" means the money that a carrier disburses to a managed behavioral health care organization for the provision of behavioral health care services to a member.

(6)] (7) "Managed behavioral health care organization" means a company, organization, PRIVATE REVIEW AGENT, or subsidiary that:

(i) contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; [or]

(ii) otherwise makes behavioral health care services available to members through contracts with health care providers; OR

(III) CONTRACTS DIRECTLY WITH AN EMPLOYER TO PROVIDE OR ADMINISTER BEHAVIORAL HEALTH CARE SERVICES TO EMPLOYEES ON BEHALF OF THE EMPLOYER.

[(7)] (8) (i) "Member" means an individual entitled to behavioral health care services from a carrier or a managed behavioral health care organization under a policy or plan issued or delivered in the State.

(ii) "Member" includes a subscriber.

[(8) "Mental health expense ratio" means the ratio of the total incurred direct care expenses for behavioral health care services in relation to the total direct payments for behavioral health care services.]

(9) "PREMIUMS AND RELATED REVENUE" MEANS REVENUE RECEIVED FROM:

(I) PREMIUMS FROM A BEHAVIORAL HEALTH CARE POLICY OR PLAN ISSUED OR DELIVERED IN THE STATE;

(II) CAPITATED FEES FOR BEHAVIORAL HEALTH CARE SERVICES CALCULATED ON A PER MEMBER PER MONTH BASIS; AND

(III) ANY INTEREST THAT ACCRUES ON THE REVENUE RECEIVED UNDER ITEMS (I) AND (II) OF THIS PARAGRAPH.

[(9)] (10) "Provider" means a person licensed, certified, or otherwise authorized under the Health Occupations Article or the Health - General Article to provide health care services.

(11) "TOTAL REVENUE" MEANS ALL REVENUE RECEIVED BY A CARRIER OR MANAGED BEHAVIORAL HEALTH CARE ORGANIZATION INCLUDING REVENUE FROM INVESTMENTS.

(B) THIS SECTION DOES NOT APPLY TO A PERSON THAT:

(1) FOR AN ADMINISTRATIVE FEE ONLY, SOLELY ARRANGES A PROVIDER PANEL FOR A CARRIER FOR THE PROVISION OF BEHAVIORAL HEALTH CARE SERVICES ON A DISCOUNTED FEE-FOR-SERVICE BASIS; AND

(2) DOES NOT ASSUME ANY RISK FOR PROVIDING BEHAVIORAL HEALTH CARE SERVICES TO MEMBERS.

[(b)] (C) (1) A carrier that owns or contracts with a managed behavioral health care organization shall distribute to its members at the time of enrollment an explanation of:

[(1)] (I) the specific behavioral health care services covered and the specific exclusions under the member's contract;

[(2)] (II) the member's responsibilities for obtaining behavioral health care services;

[(3)] (III) the reimbursement methodology that the carrier and managed behavioral health care organization use to reimburse providers for behavioral health care services; and

[(4)] (IV) the procedure that a member must utilize when attempting to obtain behavioral health care services outside the network of providers used by the carrier or managed behavioral health care organization.

[(c)] (2) The explanation that a carrier is required to distribute under [subsection (b)(3) of this section] PARAGRAPH (1)(III) OF THIS SUBSECTION shall be consistent with § 15-121(c) of this subtitle.

[(d) The Commissioner shall adopt regulations to carry out the provisions of this section.]

[(e)] (D) (1) Except as provided under paragraph (2) of this subsection, on or before [March 1] JUNE 1 of each year, each carrier that provides behavioral health care services through a company owned wholly or in part by the carrier or through a contract with a managed behavioral health care organization shall file with the Commissioner, on the form required by the [Commissioner, the mental health expense ratio for the provision of behavioral health care services to members.] COMMISSIONER:

(I) THE DIRECT BEHAVIORAL HEALTH CARE EXPENSES FOR THE PRECEDING CALENDAR YEAR; AND

(II) THE INFORMATION REQUIRED TO BE COLLECTED BY A CARRIER UNDER SUBSECTION (E) OF THIS SECTION.

(2) The requirements of paragraph (1) of this subsection do not apply when a company, for an administrative fee only, solely arranges a provider panel for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

(E) (1) ON OR BEFORE MARCH 1 OF EACH YEAR, AN ANNUAL AUDITED REPORT THAT MEETS THE SPECIFICATIONS OF PARAGRAPH (2) OF THIS SUBSECTION SHALL BE SUBMITTED TO THE COMMISSIONER BY:

(I) A CARRIER THAT PROVIDES BEHAVIORAL HEALTH CARE SERVICES THROUGH A COMPANY OWNED WHOLLY OR IN PART BY THE CARRIER;

(II) A CARRIER THAT PROVIDES BEHAVIORAL HEALTH CARE SERVICES THROUGH A CONTRACT WITH A MANAGED BEHAVIORAL HEALTH CARE ORGANIZATION; AND

(III) ANY CARRIER THAT ASSUMES RISK FOR PROVIDING BEHAVIORAL HEALTH CARE SERVICES TO MEMBERS.

(2) THE ANNUAL REPORT REQUIRED UNDER THIS SUBSECTION SHALL:

(I) BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER; AND

(II) INCLUDE FOR THE PRECEDING CALENDAR YEAR THE FOLLOWING DATA:

1. THE TOTAL REVENUE, TOTAL PREMIUM AND RELATED REVENUE, TOTAL DIRECT BEHAVIORAL HEALTH CARE EXPENSES, BEHAVIORAL HEALTH CARE ADMINISTRATIVE EXPENSES, AND PROFIT OR LOSS, EXPRESSED IN DOLLARS; AND

2. THE BEHAVIORAL HEALTH CARE LOSS RATIO, EXPRESSED AS A PERCENTAGE.

(3) THE COMMISSIONER SHALL ESTABLISH AND ADOPT BY REGULATION A METHODOLOGY TO BE USED IN THE ANNUAL REPORT THAT ENSURES A CLEAR SEPARATION OF ALL DIRECT BEHAVIORAL HEALTH CARE EXPENSES AND BEHAVIORAL HEALTH CARE ADMINISTRATIVE EXPENSES WHETHER INCURRED DIRECTLY OR THROUGH A SUBCONTRACTOR.

(4) THE CARRIER OR MANAGED BEHAVIORAL HEALTH CARE ORGANIZATION REQUIRED TO FILE A REPORT UNDER THIS SUBSECTION SHALL PERFORM AN AUDIT OF THE DATA REQUIRED IN THE REPORT AT THE CLAIMS LEVEL.

(5) FAILURE OF A CARRIER OR MANAGED BEHAVIORAL HEALTH CARE 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.

(F) EACH CARRIER REQUIRED TO FILE A REPORT UNDER SUBSECTION (D) OF THIS SECTION SHALL:

(1) PROVIDE THE INFORMATION CONTAINED IN THE REPORT TO MEMBERS AND PROSPECTIVE MEMBERS IN CLEAR, READABLE, AND CONCISE FORM; AND

(2) MAKE THE INFORMATION CONTAINED IN THE REPORT TO THE GENERAL PUBLIC IN CLEAR, READABLE, AND CONCISE FORM.

(G) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, THE COMMISSIONER SHALL MAKE PUBLICLY AVAILABLE, UPON REQUEST, THE FORM REQUIRED UNDER SUBSECTION (D) OF THIS SECTION.

(H) THE COMMISSIONER MAY ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SECTION.

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) file a consolidated financial statement in accordance with paragraph (3) of this subsection;

(ii) 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

(iii) 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.

(3) The consolidated financial statement shall:

(i) cover the managed care organization and each of its affiliates and subsidiaries; and

(ii) consist of the financial statements of the managed care organization and each of its affiliates and subsidiaries prepared in accordance with statutory accounting principles and on a form approved by the Commissioner, and certified to by an independent certified public accountant as to the financial condition, transactions, and affairs of the managed care organization and its affiliates and subsidiaries for the immediately preceding calendar year.

(c) (1) For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 75%.

(2) (i) Subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 60%.

(ii) Subparagraph (i) of this paragraph does not apply to an insurance product that:

1. is listed under § 15-1201(f)(3) of this title; or

2. is nonrenewable and has a policy term of no more than 6 months.

(iii) The Commissioner may establish a loss ratio for each insurance product described in subparagraph (ii)1 and 2 of this paragraph.

(3) The authority of the Commissioner under paragraphs (1) and (2) 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.

(4) (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.

(5) 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:

(i) if the loss ratio is less than 80% during calendar year 1997; and

(ii) during each subsequent calendar year if the loss ratio is less than 85%.

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

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

(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) On or before May 1 of each year, the Commissioner shall transmit to the Maryland Health Care Commission any information it needs to evaluate the Comprehensive Standard Health Benefit Plan as required under § 15-1207 of this title.

(2) The information provided by the Commissioner shall be specified in regulations adopted by the Commissioner in consultation with the Maryland Health Care Commission.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2003.