

Chapter 121

(House Bill 798)

AN ACT concerning

Health Insurance – Reporting Requirements – Repeal

FOR the purpose of repealing a requirement that an annual report be filed with the Maryland Insurance Commissioner by insurers, nonprofit health service plans, health maintenance organizations, dental plan organizations, and certain other persons or entities regarding a summary description of certain clinical issues and diagnostic and therapeutic services; repealing a requirement that an annual report be submitted to the Commissioner by insurers, nonprofit health service plans, and health maintenance organizations regarding health benefit plans; repealing a requirement that a private review agent submit to the Commissioner certain criteria and standards and modifications or revisions to the criteria and standards; making a conforming change; and generally relating to the repeal of reporting requirements for health insurance carriers and private review agents.

BY repealing

Article – Insurance

Section 15–123(k) and 15–10B–05(b)

Annotated Code of Maryland

(2011 Replacement Volume and 2015 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance

Section 15–123(l), (m), and (n), 15–605(a), and 15–10B–05(c), (d), and (e)

Annotated Code of Maryland

(2011 Replacement Volume and 2015 Supplement)

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

Article – Insurance

15–123.

[(k) (1) Each carrier shall file annually with the Commissioner a summary description of the clinical issues and diagnostic and therapeutic services that were evaluated and the conclusion of the evaluation, including the opinions of the clinical experts.

(2) The Commissioner shall:

(i) make each carrier's filing under paragraph (1) of this subsection available to the public for inspection and review; and

(ii) provide a copy of a carrier's filing under paragraph (1) of this subsection to any person upon request in a timely manner and at a reasonable cost to the person.]

[(l)] (K) After notifying a carrier and providing an opportunity for a hearing, the Commissioner may issue an order under § 4-113(d) of this article for a violation of this section.

[(m)] (L) (1) The Commissioner may waive the application of subsection (f) of this section for a carrier that has in place a process for evaluating emerging medical and surgical treatments used for the purpose of making coverage decisions, if the Commissioner determines that the carrier's process is substantially equivalent to, or exceeds, the requirements of this section.

(2) A carrier receiving a waiver under paragraph (1) of this subsection shall report any change in its process for evaluating emerging medical and surgical treatments to the Commissioner.

(3) The Commissioner may withdraw a waiver granted under paragraph (1) of this subsection whenever the Commissioner determines that the carrier's process for evaluating emerging medical and surgical treatments is not substantially equivalent to the requirements of this section.

[(n)] (M) The Commissioner may adopt regulations to carry out 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.]

15-10B-05.

[(b) (1) At least 10 days before a private review agent requires any revisions or modifications to existing specific criteria and standards to be used in conducting utilization review of proposed or delivered services, the private review agent shall submit those revisions or modifications to the Commissioner.

(2) At least 10 days before a private review agent requires specific criteria and standards to be used in conducting utilization review of proposed or delivered services in which there are no existing criteria or standards, the private review agent shall submit the criteria and standards to the Commissioner.]

[(c) (B) On the written request of any person or health care facility, the private review agent shall provide 1 copy of the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services to the person or health care facility making the request.

[(d) (C) The private review agent may charge a reasonable fee for a copy of the specific criteria and standards or any subsequent revisions, modifications, or additions to the specific criteria to any person or health care facility requesting a copy under subsection [(c) (B) of this section.

[(e) (D) A private review agent shall advise the Commissioner, in writing, of a change in:

(1) ownership, medical director, or chief executive officer within 30 days of the date of the change;

(2) the name, address, or telephone number of the private review agent within 30 days of the date of the change; or

(3) the private review agent's scope of responsibility under a contract.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2016.

Approved by the Governor, April 12, 2016.