

HOUSE BILL 798

C3

6lr0092

By: **Chair, Health and Government Operations Committee (By Request –
Departmental – Maryland Insurance Administration)**

Introduced and read first time: February 8, 2016

Assigned to: Health and Government Operations

Committee Report: Favorable

House action: Adopted

Read second time: March 9, 2016

CHAPTER _____

1 AN ACT concerning

2 **Health Insurance – Reporting Requirements – Repeal**

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

14 BY repealing

15 Article – Insurance

16 Section 15–123(k) and 15–10B–05(b)

17 Annotated Code of Maryland

18 (2011 Replacement Volume and 2015 Supplement)

19 BY repealing and reenacting, with amendments,

20 Article – Insurance

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

22 Annotated Code of Maryland

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.



(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.

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

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

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

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

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

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

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

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

17 1. premiums written;

18 2. premiums earned;

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

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

23 5. loss ratio; and

24 6. expense ratio.

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

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

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

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

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

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

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

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

15 15–10B–05.

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

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

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

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

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

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

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

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

6 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June
7 1, 2016.

Approved:

Governor.

Speaker of the House of Delegates.

President of the Senate.