HOUSE BILL 1386

C3 0lr2484

By: **Delegate Mizeur**
Introduced and read first time: February 18, 2010
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Disclosure of Health Premium Expenditures Act

FOR the purpose of requiring health insurance carriers to disclose certain information about the distribution of premium dollars in each statement of benefits provided to enrollees; requiring health insurance carriers to disclose in their enrollment sales materials certain aggregate loss ratios for certain health benefit plans; requiring the disclosure of certain aggregate loss ratios to be in the form that the Maryland Insurance Commissioner establishes and adopts by regulation; altering the form and manner in which health insurers, nonprofit health service plans, and health maintenance organizations are required to disclose certain loss ratios for certain health benefits plans; providing for the application of this Act; requiring the Maryland Insurance Administration to monitor certain legislation and give certain notice to the Department of Legislative Services; providing for the termination of this Act under certain circumstances; and generally relating to the disclosure by health insurance carriers of information about loss ratios for health benefit plans and the distribution of health insurance premiums.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–121 and 15–605(d)
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

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

Article – Insurance

15–121.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

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

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) any person or entity acting as 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.

(3) "Contract" means any written agreement between a provider and a carrier for the provider to render health care services to enrollees of the carrier.

(4) "Enrollee" means any person or subscriber entitled to health care benefits from a carrier.

(5) "Health care services" means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(6) (i) "Provider" means a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(ii) "Provider" includes:

1. a health care facility;

2. a pharmacy;

3. a professional services corporation;

4. a partnership;

5. a limited liability company;

6. a professional office; or

7. any other entity licensed or authorized by law to provide or deliver professional health care services through or on behalf of a provider.

(b) This section applies to a carrier that provides health care services to enrollees, or otherwise makes health care services available to enrollees, through contracts with providers.

(c) (1) Each carrier shall identify and disclose in layman's terms in its enrollment sales materials the reimbursement methodology or methodologies the carrier uses to reimburse physicians for health care services rendered to enrollees, including capitation, case rates, discounted fee–for–service, and fee–for–service reimbursement methodologies.

(2) The Maryland Health Care Commission shall develop a uniform definition in layman's terms of each reimbursement methodology required to be disclosed and identified by carriers under paragraph (1) of this subsection, including a representative example of a typical capitation arrangement between a carrier and a physician.

(d) (1) In addition to the requirements of subsection (c)(1) of this section, each carrier shall disclose **[**in its enrollment sales materials**]** the distribution of each $100 it receives in premium dollars from enrollees for the preceding calendar year, for which data are available**:**

(I) IN ITS ENROLLMENT SALES MATERIALS; AND

(II) IN EACH STATEMENT OF BENEFITS PROVIDED TO ENROLLEES.

(2) The disclosure required under paragraph (1) of this subsection shall be in the form of a pie chart or bar graph with descriptive terms and in layman's terms that identifies consistent with the National Association of Insurance Commissioners' health maintenance organization annual statement ("orange form"):

(i) the proportion of every $100 in premium dollars that the carrier uses to pay providers for the direct provision of health care services to enrollees, including what proportion is for direct medical care expenses; and

(ii) the proportion of every $100 in premium dollars that the carrier uses to pay for plan administration.

(E) (1) IN ADDITION TO THE REQUIREMENTS OF SUBSECTIONS (C)(1) AND (D)(1) OF THIS SECTION, EACH CARRIER SHALL DISCLOSE IN ITS ENROLLMENT SALES MATERIALS:

(I) THE AGGREGATE LOSS RATIO SUBMITTED TO THE COMMISSIONER FOR THE PRECEDING CALENDAR YEAR FOR HEALTH BENEFIT PLANS ISSUED UNDER SUBTITLE 12 OF THIS TITLE FOR THE SMALL GROUP MARKET;

(II) THE AGGREGATE LOSS RATIO SUBMITTED TO THE COMMISSIONER FOR THE PRECEDING CALENDAR YEAR FOR HEALTH BENEFIT PLANS ISSUED UNDER SUBTITLE 13 OF THIS TITLE FOR THE INDIVIDUAL MARKET; AND

(III) THE AGGREGATE LOSS RATIO SUBMITTED TO THE COMMISSIONER FOR THE PRECEDING CALENDAR YEAR FOR HEALTH BENEFIT PLANS ISSUED UNDER SUBTITLE 14 OF THIS TITLE FOR THE LARGE GROUP MARKET.

(2) THE DISCLOSURE OF THE AGGREGATE LOSS RATIOS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE IN THE FORM THAT THE COMMISSIONER ESTABLISHES AND ADOPTS BY REGULATION.

15–605.

(d) **(1)** 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**]** **DISCLOSE THE AGGREGATE LOSS RATIOS FOR HEALTH BENEFIT PLANS ISSUED UNDER SUBTITLES 12, 13, AND 14 OF THIS TITLE:**

(I) IN ITS ENROLLMENT SALES MATERIALS IN ACCORDANCE WITH § 15–121 OF THIS TITLE; AND

(II) ANNUALLY TO EACH CONTRACT HOLDER.

(2) THE DISCLOSURE OF THE AGGREGATE LOSS RATIOS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE IN THE FORM THAT THE COMMISSIONER ESTABLISHES AND ADOPTS BY REGULATION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, certificates, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2011.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) This Act shall remain in effect unless federal or State legislation is enacted that establishes medical loss ratio requirements at or above 80% in the individual, small group, and large group markets.

(b) The Maryland Insurance Administration shall monitor federal and State legislation relating to medical loss ratios, and shall notify the Department of Legislative Services of the enactment of legislation described in subsection (a) of this section within 10 days after the date of enactment.

(c) This Act shall be abrogated and of no further force or effect 10 days after the date the Department receives notice from the Administration under subsection (b) of this section.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2010.