HOUSE BILL 465

C3 2lr0901
CF SB 456

By: **Delegate Hammen**
Introduced and read first time: February 2, 2012
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Health Benefit Plan Premium Rate Review

FOR the purpose of prohibiting a carrier that issues or delivers a health benefit plan in the State from charging a premium to certain persons or changing a premium before the applicable premium rate or premium rate change is filed with and approved by the Maryland Insurance Commissioner; requiring any applicable premium rate or premium rate change to be filed with the Commissioner at least a certain period of time before its proposed effective date; requiring the Commissioner to require a carrier to provide certain information under certain circumstances; extending the period of time before the proposed effective date of a premium rate filing under certain circumstances; authorizing the Commissioner to authorize an earlier or later effective date of a premium rate filing; providing that a premium rate filing is deemed approved unless disapproved by the Commissioner within a certain period of time; requiring the Commissioner to disapprove or modify a proposed premium rate filing under certain circumstances; requiring the Commissioner to consider certain factors in determining whether to disapprove or modify a premium rate filing; requiring each premium rate filing and any supporting information filed to be open to public inspection; authorizing a person to obtain copies of a premium rate filing and any supporting information; authorizing the Commissioner to require a carrier to demonstrate that its premium rates and method for setting premium rates for a health benefit plan are not excessive in relation to benefits, notwithstanding the Commissioner's previous approval; requiring the Commissioner to issue a certain order to a carrier under certain circumstances; requiring the Commissioner to hold a hearing before issuing a certain order and to provide written notice of the hearing; providing that an order does not affect a certain health benefit plan; providing that each decision or finding of the Commissioner about premium rates is subject to judicial review; providing that a nonprofit health service plan and a health maintenance organization that offer a certain health benefit plan are subject to certain provisions of law; establishing the provisions of law that prevail if there is a conflict between

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

certain provisions of law; providing for the application of this Act; defining certain terms; and generally relating to health benefit plan premium rate review under health insurance.

BY adding to
Article – Insurance
Section 11–601 through 11–603 to be under the new subtitle "Subtitle 6. Health Benefit Plan Premium Rate Review"
Annotated Code of Maryland
(2011 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–126(a)
Annotated Code of Maryland
(2011 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–713(a)
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

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

Article – Insurance

SUBTITLE 6. HEALTH BENEFIT PLAN PREMIUM RATE REVIEW.

11–601.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "CARRIER" MEANS A PERSON THAT:

(1) OFFERS A HEALTH BENEFIT PLAN IN THE STATE; AND

(2) IS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION.

(C) "CONTRACT HOLDER" MEANS A PERSON TO WHICH A CARRIER HAS ISSUED A HEALTH BENEFIT PLAN.

(D) (1) "HEALTH BENEFIT PLAN" MEANS:

(I) A HEALTH INSURANCE CONTRACT, A NONPROFIT HEALTH SERVICE PLAN CONTRACT, OR A HEALTH MAINTENANCE ORGANIZATION CONTRACT THAT INCLUDES BENEFITS FOR MEDICAL CARE; OR

(II) A CERTIFICATE OF HEALTH INSURANCE ISSUED OR DELIVERED TO A MARYLAND RESIDENT UNDER A CONTRACT ISSUED TO AN ASSOCIATION LOCATED IN THE STATE OR ANY OTHER STATE.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT–ONLY INSURANCE;

7. COVERAGE FOR ON–SITE MEDICAL CLINICS; AND

8. OTHER SIMILAR INSURANCE COVERAGE, AS SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104–191, UNDER WHICH BENEFITS FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS;

(II) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE OTHERWISE NOT AN INTEGRAL PART OF A HEALTH BENEFIT PLAN:

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

2. BENEFITS FOR LONG–TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY–BASED CARE, OR ANY COMBINATION OF THESE BENEFITS; AND

3. OTHER SIMILAR LIMITED BENEFITS AS SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104–191;

(III) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS:

1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS; AND

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

(IV) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE:

1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE, AS DEFINED IN § 1882(G)(1) OF THE SOCIAL SECURITY ACT;

2. COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE; AND

3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

(E) "MEDICAL CARE" MEANS:

(1) ITEMS OR SERVICES FOR THE DIAGNOSIS, CURE, MITIGATION, TREATMENT, OR PREVENTION OF A DISEASE, INJURY, OR CONDITION AFFECTING ANY STRUCTURE OR FUNCTION OF THE BODY; AND

(2) TRANSPORTATION PRIMARILY FOR AND ESSENTIAL TO MEDICAL CARE DESCRIBED IN ITEM (1) OF THIS SUBSECTION.

11–602.

THIS SUBTITLE APPLIES TO A CARRIER THAT ISSUES OR DELIVERS A HEALTH BENEFIT PLAN IN THE STATE.

11–603.

(A) A CARRIER SUBJECT TO THIS SUBTITLE MAY NOT CHARGE A PREMIUM TO A CONTRACT HOLDER OR TO AN INDIVIDUAL COVERED UNDER A HEALTH BENEFIT PLAN BEFORE THE APPLICABLE PREMIUM RATE IS FILED WITH AND APPROVED BY THE COMMISSIONER.

(B) A CARRIER SUBJECT TO THIS SUBTITLE MAY NOT CHANGE THE PREMIUM CHARGED TO A CONTRACT HOLDER OR TO AN INDIVIDUAL COVERED UNDER A HEALTH BENEFIT PLAN UNTIL THE APPLICABLE PREMIUM RATE CHANGE HAS BEEN FILED WITH AND APPROVED BY THE COMMISSIONER.

(C) (1) (I) ANY APPLICABLE PREMIUM RATE OR PREMIUM RATE CHANGE OF A CARRIER SUBJECT TO THIS SUBTITLE SHALL BE FILED WITH THE COMMISSIONER AT LEAST 90 DAYS BEFORE ITS PROPOSED EFFECTIVE DATE.

(II) IF THE PREMIUM RATES FILED ARE NOT ACCOMPANIED BY INFORMATION SUFFICIENT FOR THE COMMISSIONER TO DETERMINE WHETHER THE PREMIUM RATE FILING MEETS THE REQUIREMENTS OF THIS SUBTITLE, THE COMMISSIONER SHALL REQUIRE THE CARRIER TO PROVIDE THE NEEDED INFORMATION.

(III) IF THE COMMISSIONER REQUIRES ADDITIONAL INFORMATION, THE 90–DAY PERIOD UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL BEGIN AGAIN ON THE DATE THE REQUIRED INFORMATION IS RECEIVED BY THE COMMISSIONER.

(IV) ON WRITTEN APPLICATION BY THE CARRIER, THE COMMISSIONER MAY AUTHORIZE A PROPOSED PREMIUM RATE THAT THE COMMISSIONER HAS APPROVED TO BECOME EFFECTIVE:

1. BEFORE THE EXPIRATION OF THE 90–DAY REVIEW PERIOD OR ANY EXTENSION OF THE 90–DAY REVIEW PERIOD; OR

2. AT A LATER DATE.

(2) A PREMIUM RATE FILING IS DEEMED APPROVED UNLESS DISAPPROVED BY THE COMMISSIONER WITHIN THE 90–DAY PERIOD OR ANY

EXTENSION OF THE 90–DAY PERIOD DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION.

(3) (I) THE COMMISSIONER SHALL DISAPPROVE OR MODIFY A PROPOSED PREMIUM RATE FILING IF THE PROPOSED PREMIUM RATES APPEAR, BASED ON STATISTICAL ANALYSIS AND REASONABLE ASSUMPTIONS, TO BE EXCESSIVE IN RELATION TO BENEFITS.

(II) IN DETERMINING WHETHER TO DISAPPROVE OR MODIFY A PREMIUM RATE FILING OF A CARRIER, THE COMMISSIONER SHALL CONSIDER:

1. PAST AND PROSPECTIVE LOSS EXPERIENCE IN AND OUTSIDE THE STATE;

2. UNDERWRITING PRACTICE AND JUDGMENT, TO THE EXTENT APPROPRIATE;

3. A REASONABLE MARGIN FOR RESERVE NEEDS;

4. PAST AND PROSPECTIVE EXPENSES, BOTH COUNTRYWIDE AND THOSE SPECIFICALLY APPLICABLE TO THE STATE; AND

5. ANY OTHER RELEVANT FACTORS IN AND OUTSIDE THE STATE.

(4) (I) EACH PREMIUM RATE FILING AND ANY SUPPORTING INFORMATION FILED UNDER THIS SUBTITLE SHALL BE OPEN TO PUBLIC INSPECTION AS SOON AS FILED.

(II) ON REQUEST AND PAYMENT OF A REASONABLE FEE, A PERSON MAY OBTAIN COPIES OF A PREMIUM RATE FILING AND ANY SUPPORTING INFORMATION.

(D) NOTWITHSTANDING THE COMMISSIONER'S PREVIOUS APPROVAL OF A PREMIUM RATE FILING OF A CARRIER SUBJECT TO THIS SECTION, THE COMMISSIONER, AT ANY TIME, MAY REQUIRE THE CARRIER TO DEMONSTRATE THAT, BASED ON STATISTICAL ANALYSIS AND REASONABLE ASSUMPTIONS AND CONSIDERING THE FACTORS LISTED IN SUBSECTION (C)(3) OF THIS SECTION, ITS PREMIUM RATES FOR A HEALTH BENEFIT PLAN ARE NOT EXCESSIVE IN RELATION TO BENEFITS.

(E) (1) IF, AFTER THE APPLICABLE REVIEW PERIOD ESTABLISHED UNDER SUBSECTION (C) OF THIS SECTION, THE COMMISSIONER FINDS THAT THE PREMIUM RATES IN A PREMIUM RATE FILING OF A CARRIER SUBJECT TO THIS SECTION ARE EXCESSIVE, AS DETERMINED UNDER SUBSECTION (C)(3) OF THIS SECTION, THE COMMISSIONER SHALL ISSUE TO THE CARRIER AN ORDER THAT:

(I) SPECIFIES THE REASONS WHY THE PREMIUM RATE FILING WAS NOT APPROVED UNDER SUBSECTION (C)(3) OF THIS SECTION; AND

(II) STATES WHEN, WITHIN A REASONABLE PERIOD AFTER THE ORDER, THE PREMIUM RATE FILING WILL NO LONGER BE EFFECTIVE.

(2) (I) THE COMMISSIONER SHALL HOLD A HEARING BEFORE ISSUING AN ORDER UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(II) THE COMMISSIONER SHALL GIVE WRITTEN NOTICE OF THE HEARING TO THE CARRIER AT LEAST 10 DAYS BEFORE THE HEARING.

(III) THE WRITTEN NOTICE SHALL SPECIFY THE MATTERS TO BE CONSIDERED AT THE HEARING.

(3) AN ORDER ISSUED UNDER PARAGRAPH (1) OF THIS SUBSECTION DOES NOT AFFECT A HEALTH BENEFIT PLAN ISSUED OR DELIVERED BEFORE THE EXPIRATION OF THE PERIOD STATED IN THE ORDER.

(F) EACH DECISION OR FINDING OF THE COMMISSIONER ABOUT PREMIUM RATES MADE UNDER THIS SUBTITLE IS SUBJECT TO JUDICIAL REVIEW IN ACCORDANCE WITH SUBTITLE 5 OF THIS TITLE.

14–126.

(a) (1) A corporation subject to this subtitle may not amend its certificate of incorporation, bylaws, or the terms and provisions of contracts issued or proposed to be issued to subscribers to the plan until the proposed amendments have been submitted to and approved by the Commissioner and the applicable fees required by § 2–112 of this article have been paid.

(2) **(I)** A corporation subject to this subtitle may not change the table of rates charged or proposed to be charged to subscribers for a form of contract issued or to be issued for health care services until the proposed change has been submitted to and approved by the Commissioner.

(II) 1. A NONPROFIT HEALTH SERVICE PLAN THAT OFFERS A HEALTH BENEFIT PLAN, AS DEFINED IN § 11–601 OF THIS ARTICLE, IS SUBJECT TO TITLE 11, SUBTITLE 6 OF THIS ARTICLE FOR THE HEALTH BENEFIT PLAN.

2. IF THE PROVISIONS OF TITLE 11, SUBTITLE 6 OF THIS ARTICLE CONFLICT WITH THE PROVISIONS OF THIS SECTION, THE PROVISIONS OF TITLE 11, SUBTITLE 6 OF THIS ARTICLE SHALL PREVAIL.

(3) The Commissioner shall approve an amendment to the articles of incorporation or bylaws under paragraph (1) of this subsection unless the Commissioner determines the amendment is contrary to the public interest.

Article – Health – General

19–713.

(a) **(1)** Each health maintenance organization shall file with the Commissioner and pay the applicable filing fee as provided in § 2–112 of the Insurance Article, before they become effective:

[(1)**] (I)** All rates that the health maintenance organization charges subscribers or groups of subscribers; and

[(2)**] (II)** The form and content of each contract between the health maintenance organization and its subscribers or groups of subscribers.

(2) (I) A HEALTH MAINTENANCE ORGANIZATION THAT OFFERS A HEALTH BENEFIT PLAN, AS DEFINED IN § 11–601 OF THE INSURANCE ARTICLE, IS SUBJECT TO TITLE 11, SUBTITLE 6 OF THE INSURANCE ARTICLE FOR THE HEALTH BENEFIT PLAN.

(II) IF THE PROVISIONS OF TITLE 11, SUBTITLE 6 OF THE INSURANCE ARTICLE CONFLICT WITH THE PROVISIONS OF THIS SECTION, THE PROVISIONS OF TITLE 11, SUBTITLE 6 OF THE INSURANCE ARTICLE SHALL PREVAIL.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2012.