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By: **Senator Van Hollen**
Introduced and read first time: February 6, 1998
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 26, 1998

CHAPTER_____

AN ACT concerning

~~**Maryland Insurance Commissioner - Behavioral Managed Care Administrators**~~
Managed Behavioral Healthcare Organizations - Disclosure

~~FOR the purpose of requiring a behavioral managed care administrator that provides mental health and substance abuse services to submit a certain annual report to the Maryland Insurance Commissioner concerning certain expenses and loss ratios of the behavioral managed care administrator; providing a certain penalty for the failure of a certain behavioral managed care administrator to submit a certain report; prohibiting a certain behavioral managed care administrator from having a loss ratio of less than a certain amount; and generally relating to certain behavioral managed care administrators.~~

FOR the purpose of requiring a carrier that owns or contracts with a managed behavioral healthcare organization for the provision of behavioral health care services to provide a certain referral policy to enrollees; requiring a managed behavioral healthcare organization to file certain information with the Insurance Commissioner under certain circumstances; requiring a carrier to distribute certain information to enrollees; defining terms; providing for the application of this Act; and generally relating to managed behavioral healthcare organizations.

BY adding to
Article - Health - General
Section 19-706(y)
Annotated Code of Maryland

(1996 Replacement Volume and 1997 Supplement)

~~BY repealing and reenacting, with amendments,~~

BY adding to
Article - Insurance
Section ~~15-605~~ 15-124
Annotated Code of Maryland
(1997 Volume)

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

Article - Health - General

19-706.

(Y) THE PROVISIONS OF § 15-124 OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article - Insurance

~~15-605.~~

~~(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.~~

~~(2) "BEHAVIORAL MANAGEMENT CARE ADMINISTRATOR" MEANS AN ENTITY THAT DOES BUSINESS AS, OR CONTRACTS WITH, A MANAGED CARE ORGANIZATION OR HEALTH MAINTENANCE ORGANIZATION TO ACT AS A THIRD PARTY ADMINISTRATOR OR PRIVATE REVENUE AGENT OR MENTAL HEALTH AND ABUSE SERVICES.~~

~~(3) "HEALTH BENEFIT PLAN" INCLUDES A PLAN THAT PROVIDES MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS.~~

~~(B) ON OR BEFORE MARCH 1 OF EACH YEAR EACH BEHAVIORAL MANAGED CARE ADMINISTRATOR OPERATING IN MARYLAND SHALL SUBMIT TO THE COMMISSIONER, IN A FORM REQUIRED BY THE COMMISSIONER, ITS LOSS RATIO AND EXPENSE RATIO.~~

~~[(a)] (C) (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;~~

~~(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 may conduct an examination to ensure that an annual report submitted under this subsection is accurate.~~

~~(5) Failure of an insurer, nonprofit health service plan, [or] health maintenance [organization] ORGANIZATION, OR BEHAVIORAL MANAGED CARE ADMINISTRATOR to submit the information required under this subsection OR~~

~~SUBSECTION (B) in a timely manner shall result in a penalty of $500 for each day after March 1 that the information is not submitted.~~

~~[(b)] (D) (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)] (B), (C)(3)(iii), and [(c)] (E)(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)] (E) (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)] (F) 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)] (G) (1) On or before May 1 of each year, the Commissioner shall transmit to the Health Care Access and Cost 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 Health Care Access and Cost Commission.~~

~~(H) A BEHAVIORAL MANAGED CARE ADMINISTRATOR MAY NOT HAVE A LOSS RATIO OF LESS THAN 75%.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1998.~~

15-124.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION" MEANS A COMPANY THAT:

(I) UNDERTAKES TO ARRANGE FOR OR ADMINISTERS THE PROVISION OF BEHAVIORAL HEALTH CARE SERVICES TO ENROLLEES; OR

(II) MAKES BEHAVIORAL HEALTH CARE SERVICES AVAILABLE TO ENROLLEES THROUGH CONTRACTS WITH PROVIDERS.

(3) "BEHAVIORAL HEALTH CARE SERVICES" MEANS TREATMENT PROCEDURES OR SERVICES RENDERED BY A PROVIDER FOR THE TREATMENT OF MENTAL ILLNESS, EMOTIONAL DISORDERS, DRUG ABUSE, OR ALCOHOL ABUSE.

(4) "CARRIER" MEANS:

(I) A HEALTH INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION;

(V) A PREFERRED PROVIDER ORGANIZATION;

(VI) A THIRD PARTY ADMINISTRATOR; OR

(VII) 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.

(5) "ENROLLEE" MEANS A PERSON ENTITLED TO BEHAVIORAL HEALTH CARE SERVICES FROM A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION UNDER A POLICY, PLAN, OR CERTIFICATE ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

(6) "PROVIDER" MEANS A PERSON LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE OR THE HEALTH - GENERAL ARTICLE TO PROVIDE HEALTH CARE SERVICES.

(B) (1) IF A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION REQUIRES AN ENROLLEE TO OBTAIN A REFERRAL FOR THE PROVISION OF BEHAVIORAL HEALTH CARE SERVICES, THE CARRIER SHALL PROVIDE THE ENROLLEE WITH THE REFERRAL POLICY OF THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION AT THE TIME OF ENROLLMENT.

(2) A CARRIER THAT OWNS OR CONTRACTS WITH A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION SHALL DISTRIBUTE TO ENROLLEES OF THE CARRIER:

(I) AN EXPLANATION OF THE SPECIFIC BEHAVIORAL HEALTH CARE SERVICES COVERED BY AND THE SPECIFIC EXCLUSIONS OF THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION;

(II) AN EXPLANATION OF THE ENROLLEE'S RESPONSIBILITIES FOR OBTAINING A REFERRAL FOR THE PROVISION OF BEHAVIORAL HEALTH CARE SERVICES;

(III) AN EXPLANATION OF THE REIMBURSEMENT METHODOLOGY THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION USES TO REIMBURSE PROVIDERS FOR BEHAVIORAL HEALTH CARE SERVICES RENDERED TO ENROLLEES;

(IV) AN EXPLANATION OF THE PROCEDURE AN ENROLLEE MUST UTILIZE WHEN ATTEMPTING TO OBTAIN BEHAVIORAL HEALTH CARE SERVICES, WITHOUT A REFERRAL, OUTSIDE OF THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION'S NETWORK OF PROVIDERS; AND

(V) AN EXPLANATION OF THE CARRIER'S PROCESS FOR APPEALING A PAYMENT DENIAL.

(C) THE EXPLANATION THAT A CARRIER IS REQUIRED TO PROVIDE UNDER SUBSECTION (B)(3)(III) OF THIS SECTION SHALL BE CONSISTENT WITH § 15-121(C) OF THIS SUBTITLE.

(D) (1) EXCEPT AS PROVIDED UNDER PARAGRAPH (2) OF THIS SUBSECTION, ON OR BEFORE MARCH 1 OF EACH YEAR, EACH CARRIER THAT OWNS OR CONTRACTS WITH A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION SHALL FILE WITH THE COMMISSIONER, IN A FORM REQUIRED BY THE COMMISSIONER, THE TOTAL INCURRED CARE EXPENSES OF THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FOR BEHAVIORAL HEALTH CARE SERVICES IN RELATION TO THE

TOTAL PAYMENTS FROM THE CARRIER TO THE MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION ON BEHALF OF ENROLLEES OF THE CARRIER.

(2) THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION DO NOT APPLY TO A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION THAT, 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) THE COMMISSIONER SHALL ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act applies to any new policy, contract, certificate, or evidence of coverage under a health benefit plan that a carrier issues or delivers in the State on or after July 1, 1998.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act applies on or after January 1, 1999 to the renewal of any policy, contract, certificate, or evidence of coverage under a health benefit plan that a carrier issues or delivers in the State that is in effect before July 1, 1998.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1998.