(3) Of the total assessment apportioned under paragraph (2) of this subsection to payors within the meaning of subsection (a)(3)(i) of this section, the Commissioner shall assess each such payor a fraction:

(i) The numerator of which is the payor's total premiums collected in the State for health benefit plans for an appropriate prior 12–month period as determined by the Commissioner; and

(ii) The denominator of which is the total premiums for health benefit plans of all such payors collected in the State for the same period.

(4) Of the total assessment apportioned under paragraph (2) of this subsection to payors within the meaning of subsection (a)(3)(ii) of this section, the Commissioner shall assess each such payor a fraction:

(i) The numerator of which is the payor's total administrative fees collected in the State for health benefit plans for an appropriate prior 12–month period as determined by the Commissioner; and

(ii) The denominator of which is the total administrative fees of all such payors collected in the State for health benefit plans for the same period.

(c) (1) Subject to paragraph (2) of this subsection, on or before September 1 of each year, each payor assessed a fee in accordance with this section shall make payment to the Commissioner.

(2) The Commissioner, in cooperation with the Maryland Health Care Access and Cost Commission, may make provisions for partial payments.

(d) The Commissioner shall distribute the fees collected under this section to the health care access and cost fund established under [§ 19–1514] § 19–1515 of the Health – General Article.

(e) All payors shall cooperate fully in submitting reports and claims data and providing any other information to the Maryland Health Care Access and Cost Commission in accordance with Title 19, Subtitle 15 of the Health – General Article.

(f) In making payments for health care services, all payors shall pay in accordance with the payment system adopted under § 19–1509 of the Health – General Article.

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(A) All authorized insurers, including nonprofit health service plans and fraternal benefit societies, shall pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission.

(B) (1) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE STATE AND PROVIDES HEALTH INSURANCE IN THE STATE, EACH HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE, AND EACH NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO OPERATE IN THE STATE SHALL SUBMIT AN ANNUAL