*Article 48A – Insurance Code*

*490S.*

*(a) All authorized insurers, including nonprofit health service plans, [and] fraternal benefit societies, AND MANAGED CARE ORGANIZATIONS AUTHORIZED TO RECEIVE MEDICAID PREPAID CAPITATION PAYMENTS UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE, 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, AND, 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, shall submit an annual report in a form required by the Commissioner that includes, for the preceding calendar year, the following data in the aggregate for all health benefit plans specific to this State:*

*(i) Premiums written;*

*(ii) Premiums earned;*

*(iii) Total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;*

*(iv) Total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, using estimates when necessary;*

*(v) Loss ratio; and*

*(vi) Expense ratio.*

*(2) (i) If the loss ratio of an insurer, other than an insurer that provides health insurance exclusively to individuals, or health maintenance organization, is less than 75 percent or if its expense ratio is more than 20 percent, the Commissioner may require the insurer or health maintenance organization to file new rates for its health benefit plans.*

*(ii) If the loss ratio of a nonprofit health service plan is less than 75 percent or if the expense ratio of a nonprofit health service plan is more than 18 percent, the Commissioner may require the nonprofit health service plan to file new rates for its health benefit plans.*

*(iii) The authority of the Commissioner to require an insurer to file new rates based on the insurer's loss ratio under this paragraph shall be deemed to be in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory and may not be construed to limit any existing authority of the Commissioner to determine whether a rate is excessive.*

*(3) In determining whether to require an insurer to file new rates under paragraph (2) of this subsection, the Commissioner may consider the amount of health*