MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
David Sharp, Acting Executive Director

April 18, 2025

Dear Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations:

The Maryland Health Care Commission (MHCC) is requesting the information necessary to calculate the *Fiscal Year 2026 User Fee Assessment* (Survey), as authorized by Health-General Article §19-111. This statute permits the Commission to levy an assessment on all "payors."

Under §19-111(a)(6), a "payor" is defined as:

(i) A health insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in the State in accordance with this article of the insurance article; or

(ii) A health maintenance organization that holds a certificate of authority in the State.

All payors are required to complete the Survey no later than April 30, 2025. The MHCC is authorized to impose a fine of up to $1,000 per day for late submissions. Prompt responses help ensure that MHCC can accurately determine each payor's assessment based on the submitted data. Please take the time to review, verify, and update your organization's information, including contact details, to ensure accurate communication and processing.

Payors must report total written premiums in Maryland for health benefit plans, as defined by Insurance Article §15-1201, for calendar year 2024. Companies that do not offer these plans are excluded from filing. Please carefully review the definitions and exclusions on the following pages before submitting your data. Submission errors cannot be corrected once the assessment has been billed and may impact other insurers. Each payor's fee is calculated based on its share of total premiums written in Maryland during 2024.

We also request that organizations with vision or dental premiums complete the survey. Although these premiums are not subject to assessment, MHCC collects this data to identify payors who may be required to comply with:

- COMAR 10.25.06 – Medical Care Data Base and Data Collection
- COMAR 10.25.09 – Requirements for Payers to Designate Electronic Health Networks

If you have any questions about your Survey, please contact me at (410) 764-3558 or by email at richard.proctor@maryland.gov. Thank you for your cooperation.

Sincerely,

Richard Proctor
Chief Operating Officer

Attachment: Maryland Insurance Article §15-1201

The Insurance Article §15-1201 (i) states that:

(1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health services plan; or

(iii) a health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

(3) "Health benefit plan" does not include:

(i) accident–only insurance;

(ii) credit health insurance;

(iii) disability income insurance;

(iv) coverage issued as a supplement to liability insurance;

(v) workers' compensation or similar insurance;

(vi) automobile medical payment insurance;

(vii) the following benefits, if the benefits are provided under a separate policy, certificate, or contract, or are not otherwise an integral part of a small employer health benefit plan:

1. dental benefits;

2. vision benefits;

3. long–term care insurance as defined in § 18–101 of this article;

(viii) disease–specific insurance if:

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer; and

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer;

(ix) hospital indemnity or other fixed indemnity insurance if:

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer;

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer; and

4. the benefits are payable in a fixed dollar amount per period of time, regardless of the amount of expenses incurred; or

(x) the following supplemental benefits, if the benefits are provided under a separate policy, certificate, or contract:

1. a Medicare supplement policy as defined in § 15–901 of this title;

2. coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

3. similar supplemental coverage provided to coverage under a group health plan if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).