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### BULLETIN 15- 20

**To: All Interested Parties Including Insurers, Non-Profit Health Service Plans, Health Maintenance Organizations, Dental Plan Organizations, Pharmacy Benefit Managers, and Producers**

**Re: Summary of 2015 Insurance Legislation Signed into Law  
By Governor Larry Hogan**

**Date: July 2, 2015**

This summary is meant to place insurers, nonprofit health service plans, health maintenance organizations, dental plan organizations, pharmacy benefits managers, and producers (regulated entities) authorized to do business in Maryland on notice of certain laws passed during the 2015 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration ("MIA"). *The attached summary is intended only as notice of passage of the legislation and is not a representation of the MIA's interpretation of the new law, nor is it a representation of how the MIA may enforce these new provisions.* All regulated entities should refer to the Chapter Laws of Maryland for the 2015 Session for the complete text of these recently enacted laws. Regulated entities are advised that other bills passed by the General Assembly and not listed on the summary may also affect their business operations in Maryland.

You may obtain a copy of a specific law passed by the General Assembly during the 2015 Session by accessing the Maryland General Assembly's web site at <http://mgaleg.maryland.gov> or by contacting the Department of Legislative Services at (410) 946-5400. You should refer to the House or Senate Bill number when searching for a law on the web site. You may also obtain a copy of "*The 90 Day Report – A Review of the 2015 Legislative Session*" on the Internet or from Library and Information Services, Office of Policy Analysis, Department of Legislative Services.

For additional information concerning the MIA's summary of 2015 insurance legislation, please contact Nancy Egan at (410) 468-2488 or [nancy.egan@maryland.gov](mailto:nancy.egan@maryland.gov).

## 2015 INSURANCE LEGISLATION

### LIFE AND HEALTH

#### **HOUSE BILL 230 (Chapter 79) – Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Repeal of Termination Date**

Repealing the termination date of September 30, 2015 for Chapter 537 of the Acts of 2010 relating to the assignment of benefits and reimbursement of nonpreferred providers.

*Effective Date: June 1, 2015*

#### **HOUSE BILL 552 (Chapter 494) – Health Insurance-Medical Stop-Loss Insurance-Small Employers**

- Increases the minimum specific attachment point for medical stop-loss insurance contracts from \$10,000 to \$22,500.
- Increases the minimum aggregate attachment point for medical stop-loss insurance contracts from 115% of expected claims to 120% of expected claims.
- Provides an exception to the increased minimum specific and aggregate attachment points for medical stop-loss insurance policies:
  - Issued or delivered before June 1, 2015;
  - Issued or delivered on or after June 1, 2015 to an employer that on May 31, 2015 held a policy or contract of medical stop-loss insurance with a specific attachment point of not less than \$10,000 and an aggregate attachment point of not less than 115% of expected claims *and* the contract contains to maintain a specific attachment point of not less than \$10,000 and an aggregate attachment point of not less than 115% of expected claims.
- Specifies a medical stop-loss insurer may not: (1) impose higher cost sharing for a specific individual within a small employer's health benefit plan than is required for other individuals within the plan; (2) decrease or remove stop-loss coverage for a specific individual within a small employer's health benefit plan; or (3) exclude any employee or dependent from a policy or contract based on an actual or expected health status-related factor or condition.
- Establishes that a medical stop-loss insurer shall:
  - Guarantee rates for at least 12 months for a medical stop-loss insurance contract issued to a small employer, unless there is a change in (a) benefits, (b) ownership and control of the small employer, or (c) a change in the number of covered lives by a significant percentage resulting from specified events;

- Pay stop-loss claims incurred during the policy or contract period and submitted within 12 months after the expiration of the policy or contract; and
- Disclose to the small employer the total costs, the effective and termination dates, renewal provisions, attachment points, and limitations on coverage of the policy or contract.
- Requires the MIA to conduct a study on the use of medical stop-loss insurance and submit an interim report by December 1, 2015, and a final report by October 1, 2016.
- Provides that the bill sunset on June 30, 2018.

*Effective Date: June 1, 2015*

**HOUSE BILL 562 (Chapter 434) – Health Insurance-Ambulance Service Providers-Direct Reimbursement-Repeal of Termination Date**

- Repeals the termination date of June 30, 2015 for Chapters 425 and 426, Acts of 2011 relating to the reimbursement of ambulance service providers.

*Effective Date: June 1, 2015*

**HOUSE BILL 565 (Chapter 96) – Insurance – Surplus Lines – Disability Insurance**

- Authorizes disability insurance to be procured from a nonadmitted insurer in the State as a surplus line if the coverage is in excess of coverage available from an admitted insurer, or is not available from an admitted insurer in the State that writes that particular class of insurance in the State.
- Applies to disability insurance that provides for lost income, revenue, or other proceeds in the event of an illness, accident, or injury results in a disability that impairs the insured’s ability to work or generate income.
- Does not apply to disability insurance for medical expenses, dismemberment, or accidental death.
- Requires the surplus lines disability insurance to meet the requirements specified for surplus lines including the requirement that a diligent search is made among admitted insurers that write the particular kind and class of insurance being sought, before the surplus lines disability insurance may be purchased.

*Effective Date: October 1, 2015*

**HOUSE BILL 759 (Chapter 274) – Health Insurance-Small Employer Health Benefit Plan Premium Subsidy Program-Repeal**

- Repeals the Small Employer Health Benefit Plan Premium Subsidy Program.

*Effective Date: June 1, 2016*

**HOUSE BILL 838/ SENATE BILL 416 (Chapter 483/Chapter482) – Health Insurance-Coverage for Infertility Services**

- Prohibits insurers, nonprofit health service plans, and health maintenance organizations (“carriers”) that provide coverage for infertility benefits other than in vitro fertilization (“IVF”) from requiring, as a condition of that coverage, for a patient who is married to an individual of the same sex, that the patient’s spouse’s sperm be used in the covered treatments or procedures or that the patient demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse.
- Prohibits carriers that provide pregnancy-related benefits from excluding benefits for outpatient expenses related to IVF for married couples of the same sex, if the patient’s oocytes are fertilized with donor sperm.
- Provides that a patient and the patient’s spouse may demonstrate a history of involuntary infertility by a history of (1) if the patient and the patient’s spouse are of opposite sexes, intercourse of at least two years’ duration failing to result in pregnancy or (2) if the patient and the patient’s spouse are of the same sex, six attempts of artificial insemination over the course of two years failing to result in pregnancy.
- Clarifies IVF procedures be performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
- Clarifies carriers are not responsible for any costs incurred by a policyholder, subscriber, or dependent in obtaining donor sperm for a patient who is married to an individual of the same sex.”
- Specifies that a denial of coverage for IVF benefits constitutes an adverse decision.
- Specifies that the bill does require coverage for a treatment or procedure that would not treat a diagnosed medical condition of a patient.

*Effective Date: July 1, 2015*

**HOUSE BILL 859 (Chapter 108) – Nonprofit Health Service Plans – Hearing and Order – Impact of Law or Regulatory Action by Another State**

- Clarifies that the Commissioner may conduct an examination or hold a hearing in response to a law enacted by another state or a regulatory action of another state requiring a nonprofit health service plan to distribute or reduce a nonprofit health service plan’s surplus.
- Expands the permissible actions of an order to include prohibiting the nonprofit health service plan from distributing or reducing its surplus for the benefit of residents of

another state or any other action the Commissioner considers necessary to protect Maryland subscribers.

Prohibits a nonprofit health service plan from distributing surplus or reducing its surplus under certain circumstances

*Effective Date: April 14, 2015*

**SENATE BILL 241 (Chapter 23) – Health Insurance – Coverage for Ostomy Equipment and Supplies – Required**

- Requires carriers that provide hospital, medical, or surgical benefits to provide coverage for all medically appropriate and necessary equipment and supplies for the treatment of ostomies.
- Indicates that medically appropriate and necessary equipment and supplies for the treatment of ostomies includes flanges, collection bags, clamps, irrigation devices, sanitizing product, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.
- Specifies coverage of equipment and supplies used for the treatment of ostomies may be subject to the annual deductibles or coinsurance requirements imposed by a carrier for similar coverage under the same policy or contract. The annual deductibles or coinsurance requirements imposed may not be greater than the annual deductibles or coinsurance requirements imposed by the carrier for similar coverage.
- Establishes the bill does not apply to a policy or contract issued or delivered by an entity subject to the bill that provides the essential health benefits required under the federal Affordable Care Act.

*Effective Date: October 1, 2015*

**SENATE BILL 325 (Chapter 25) – Life Insurance – Reserve Investments – Loans Secured by Real Estate**

- Revises the reserve investment requirements for life insurers from previously requiring that all loans authorized by §5-511 provide for amortization of principal over a period of not more than 30 years to requiring amortization only for certain loans relating to residential property or farm property with a loan amount not to exceed \$500,000.

*Effective Date: October 1, 2015*

**SENATE BILL 450 (Chapter 35) – Health Insurance – Expense Reimbursement Claims Forms – Methods of Submission**

- Requires carriers to permit an insured, subscriber, or member seeking reimbursement for expenses to submit a claim by first-class mail and at the election of the carrier, fax or a secure website may be used.

- Requires a carrier to provide annually:
  - A notice that claims may be submitted by first class mail or, as elected by the carrier, by fax or through a secure website.
  - Instructions on how to submit a claim by fax or through a secure website.
- Specifies that the bill does not apply to claims for reimbursement under Medicare supplemental policies or contracts or for pharmaceutical or vision services.
- Requires a carrier to comply by the earlier of the date by which a carrier's claim processing system is capable of complying with the Act or by October 1, 2017.

*Effective Date:           October 1, 2015*

**SENATE BILL 555 (Chapter 40) – Life Insurance – Cash Surrender Values – Supplemental Benefits**

- Clarifies that the requirements for calculating cash values in life insurance policies found in § 16-309 of the Insurance Article also apply to supplemental benefits found in riders to life insurance policies.

*Effective Date:           October 1, 2015*

**SENATE BILL 556 (Chapter 363) – Health Insurance-Selection of State Benchmark Plan and Required Conformity with Federal Law**

- Specifies that the Commissioner has the authority to enforce the prescription drug benefit requirements of the Affordable Care Act (“ACA”).
- Repeals obsolete language that described the annual limitation on deductibles for employer-sponsored plans.
- Amends the mental health and substance use disorder mandate to comply with the federal Mental Health Parity and Addiction Equity Act.
- Alters the definition of “full-time employee” and “health benefit plan” to comply with ACA requirements.
- Alters provisions relating to special open enrollment periods and triggering events in the small group market to conform with the requirements in ACA regulations.
- Adds new definitions of the terms “plan,” “product,” and “uniform modification of coverage” for the individual and small group markets that comply with new definitions found in ACA regulations.

- Amends the small group renewal requirements to require a carrier to mail a renewal notice to a small employer at least 60 days rather than 45 days before the expiration of a health benefit plan.
- Specifies that a carrier may make a uniform modification of coverage for a product only at the time of renewal. For plans modified at the time of renewal, the bill specifies the circumstances under which the plan shall be considered to be the same plan.
- Provides a 90-day notice of termination of small employer and large employer coverage by a health maintenance organization (“HMO”) if the cause of termination of coverage is the fact that there is no longer any enrollee who lives, resides, or works in the HMO’s approved service area.
- Repeals obsolete provisions regarding certificates of creditable coverage used to reduce preexisting condition limitations, which are no longer applicable under ACA.
- Repeals obsolete definitions of “high level policy form” and “low level policy form” and repeals provisions describing rating requirements for high and low level policy forms, which are no longer permitted under ACA.
- Specifies that a carrier shall provide a 90 calendar day notice if an individual in the individual market is terminated from coverage due to no longer living, residing or working in the service area.
- Specifies the required time that carriers shall provide renewal notices in the individual health benefit plan market
- Links the annual open enrollment period for the individual health benefit plan market to the dates adopted by the U.S. Department of Health and Human Services.
- Amends the special enrollment periods for the individual health benefit plan market to comply with the federal requirements found in ACA regulations.
- Provides that a carrier that offers a student health plan is not required to accept individuals who are not students or dependents of covered students; establish open enrollment periods; establish effective dates based on a calendar year; offer health benefit plan contracts on a calendar year basis; or renew, or continue in force, coverage for individuals who are no longer students or dependents of students.
- Provides that a student health plan is not subject to the single risk pool requirement under § 1312(c) of the ACA.
- Adds a new definition of “product” for the large employer market that complies with the corresponding definition in ACA regulations.
- Amends the definition of a “wellness program,” to be consistent with § 15-509 of the Insurance Article and in conformity with federal regulations.

- Clarifies that the wellness programs governed by § 27-210 of the Insurance Article are those provided as a benefit outside of the health insurance or HMO contract. Wellness benefits found in health benefit contracts remain subject to § 15-509 of the Insurance Article.
- Establishes rules for the selection of State benchmark plan for 2017 by the Insurance Commissioner, in consultation with Maryland Health Benefit Exchange (MHBE).
- Requires the Insurance Commissioner to submit a report to specified committees of the General Assembly within 10 days of selecting the benchmark plan.

*Effective Date: April 14, 2015*

**SENATE BILL 573 (Chapter 367) – Insurance-Standard Valuation Law and Reserve and Nonforfeiture Requirements**

- Requires insurance companies, on or after the operative date of a valuation manual adopted by the National Association of Insurance Commissioners (“NAIC”), to value their reserves for life insurance policies, accident and health insurance contracts, and deposit-type contracts using principle-based reserving (“PBR”) that is established by the valuation manual. Once adopted, PBR will replace the current formulaic approach to determining policy reserves.
- Provides that in the event that there is a conflict between Maryland law and the valuation manual, the conflict must be resolved in favor of Maryland law.
- Establishes the operative date of the valuation manual is January 1 of the first calendar year following the first July 1 in which all of the following have occurred: (1) the valuation manual has been adopted by NAIC by an affirmative vote of the greater of at least 42 members or 75% of members voting; (2) the Standard Valuation Law (“SVL”) or similar legislation has been enacted by states representing greater than 75% of direct premiums written; and (3) the SVL or similar legislation has been enacted by at least 42 of 55 specified jurisdictions.
- Allows insurers a three year transition period beginning on the operative date of the valuation manual before required compliance with PBR standards. Companies can implement PBR within that three-year period by choice, so the PBR implementation dates for companies will vary.
- Requires that life insurers, nonprofit health service plans, and fraternal benefit societies must annually submit to the Insurance Commissioner the opinion of a qualified actuary discussing whether the reserves and related actuarial items held in support of the policies, contracts, and benefit agreements are: (1) computed appropriately; (2) based on assumptions that satisfy contractual provisions; (3) consistent with prior reported amounts; and (4) in compliance with applicable laws of the State. This requirement continues to apply to each insurance company that, on or after the operative date of the valuation manual, has outstanding life insurance policies, accident and health insurance



contracts, or deposit-type contracts in the State and is subject to regulation by the Commissioner.

- Requires the valuation manual must prescribe the contents of the opinion and any other items considered necessary to the scope of the opinion.
- Establishes life insurance policies issued on or after the operative date of the valuation manual must follow the standard prescribed in the valuation manual as the minimum standard of valuation.
- Requires an insurance company to comply with the minimum valuation standard prescribed by the Commissioner by regulation in the absence of valuation requirements in the valuation manual.
- Provides that the Commissioner may engage a qualified actuary, at the expense of the insurance company to perform an actuarial examination. In addition, the Commissioner may require the insurance company to change any assumption or method used in the analysis if the Commissioner considers it necessary. An insurance company must adjust its reserves as required by the Commissioner.
- Requires an insurance company that uses a principle-based valuation to: (1) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with the valuation manual; (2) provide an annual certification of the effectiveness of the insurance company's internal controls with respect to the principle-based valuation; and (3) develop, and file with the Commissioner on request, a principle-based valuation report that complies with the valuation manual.
- Requires insurance companies to submit the mortality data, morbidity data, policyholder behavior, expense experience, and other data as prescribed in the valuation manual.
- Specifies that an insurance company's confidential information (1) is confidential and privileged; (2) is not subject to the Maryland Public Information Act; and (3) is not subject to subpoena or discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use, share, and receive confidential information under specified circumstances and to enter into agreements governing the sharing and use of confidential information.
- Allows the Insurance Commissioner to grant exemptions from the requirements of using the valuation manual for domestic insurers that have ordinary life premiums less than a specified amount and that meet other criteria. A domestic insurer that is granted an exemption must compute reserves using assumptions and methods used before the operative date of the valuation manual.
- Establishes the minimum nonforfeiture standard for life insurance policies issued before the operative date of the valuation manual and for policies issued on or after the effective date of the valuation manual.

***Effective Date:           October 1, 2015***

**SENATE BILL 606 (Chapter 372) – Health Insurance-Abuse-Deterrent Opioid Analgesic Drug Products-Coverage**

- Requires carriers that provide prescription drug coverage to provide coverage for (1) at least two brand-name abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients and (2) if available, at least two generic abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients. The required offerings of abuse deterrent opioid analgesic brand-name or generic drug product must be on the lowest cost tier for brand-name or generic prescription drugs on the carrier’s drug formulary, respectively.
- Prohibits carriers from requiring an insured or enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity’s prescription drug formulary.
- Establishes that carriers may undertake utilization review, including preauthorization, for abuse-deterrent opioid analgesic drug products covered by the carrier, if the same requirements are applied to non-abuse-deterrent opioid analgesic drug products covered by the carrier in the same formulary tier as the abuse-deterrent opioid analgesic product.

*Effective Date: January 1, 2016*

**SENATE BILL 792 (Chapter 383) – Public Health-Nondiscrimination in Access to Anatomical Gifts and Organ Transplantation**

- Creates a new subtitle in the Health-General Article that establishes rules regarding nondiscrimination in access to anatomical gifts and organ transplantation.
- Adds a new unfair trade practice prohibition within the Insurance Article that prohibits insurers, nonprofit health service plans and HMO that provide coverage for organ transplantation from denying coverage for organ transplantation solely on the basis of an insured’s or enrollee’s disability.

*Effective Date: May 12, 2015*

## **PROPERTY AND CASUALTY**

### **HOUSE BILL 358 (Chapter 88) – Workers’ Compensation Insurance-Cancellation and Nonrenewal – Notice**

- Increases the number of days to at least 45 days before the date of cancellation or renewal within which an insurer is required to provide a specified notice to an employer before the insurer may cancel or refuse to renew the employer’s workers’ compensation insurance policy midterm/before its expiration for a reason other than nonpayment of premium.
- Specifies the notice must contain (1) the date the cancellation or nonrenewal takes effect and (2) the actual reason the insurer is proposing to cancel or refuse to renew the policy. The notice must also be filed with the Workers’ Compensation Commission.

*Effective Date: January 1, 2016*

### **HOUSE BILL 630 (Chapter 444) – Transportation-Mechanical Repair Contracts**

- Alters the definition of a “mechanical repair contract” to include an agreement or contract sold by an obligor under which the obligor agrees to perform any of several services enumerated in the bill, which generally pertain to the repair, replacement, or maintenance of a vehicle including, among other things, towing, rental and emergency road service, and road hazard protection.
- Excludes from this definition warranties under the federal Magnuson-Moss Warranty Act, contracts or agreements for regular maintenance, or an agreement between a motor club and a club member or subscriber.
- Prohibits a person that is not a vehicle manufacturer (or subsidiary), distributor, factory branch, or dealer and that sells a mechanical repair contract from making a false, deceptive, or misleading statement with respect to: (1) the person’s affiliation or possession of specified information; (2) the expiration of a manufacturer’s original equipment warranty; or (3) a requirement that the vehicle owner register for a new mechanical repair contract in order to maintain coverage under the owner’s current mechanical repair contract or the manufacturer’s original equipment warranty.
- Requires an obligor to file at least 45 days prior to selling a mechanical repair contract, the contract with the Insurance Commissioner along with evidence that the obligor maintains adequate insurance reserves. The Commissioner may suspend the use of a contract after an investigation and hearing that finds the contract is not in compliance with the bill’s requirements.
- Requires the obligor of a mechanical repair contract to register with the Insurance Commissioner annually and pay a \$25 fee. The registration must include specified information including the obligor’s name, corporate address, and telephone number and the name and address of a designated agent authorized to accept service on behalf of the

obligor in the State. Unless the person is a licensed vehicle dealer, a person that is not a registered obligor may not offer, sell, or negotiate a mechanical repair contract.

- Authorizes the Insurance Commissioner to pursue an action against an unregistered person that offers a mechanical repair contract; for the same offense, it establishes a misdemeanor penalty of up to \$1,000, up to one year imprisonment, or both, not including the payment of restitution, which may also be imposed.
- Requires the obligor of a mechanical repair contract executed on or before October 1, 2015, to register with the Commissioner within 90 days of the date that the registration application is made available. It requires a person that is not engaging in mechanical repair contract transactions on October 1, 2015, to register with the Commissioner before a mechanical repair contract is offered.
- Specifies that a mechanical repair contract may not provide indemnification for a loss caused by “perils that are commonly covered by comprehensive or collision provisions” of an auto insurance policy.
- Requires each mechanical repair contract to include: (1) the name, corporate address, and telephone number of the obligor and the mechanical repair contract seller and (2) the right of the purchaser to make a direct claim against the insurer issuing a policy of insurance upon the failure of the obligor to pay a claim or make a refund or consideration due within 60 days after the proof is filed with the obligor.

*Effective Date:           October 1, 2015*

**SENATE BILL 142 (Chapter 16) – Property and Casualty Insurance – Premium Finance Companies – Assignment of Rights and Obligations – Repeal of Termination Date**

- Repeals the termination date for Chapter 334 of 2013 relating to premium finance companies and the assignment of rights and obligations which:
  - Authorizes premium finance companies to assign all rights and obligations under a premium finance agreement to another premium finance company or pledge a premium finance agreement as collateral for a loan under certain circumstances.
  - Establishes that if a premium finance agreement is for the payment of private passenger motor vehicle insurance and/or personal insurance, a premium finance company is authorized to (1) assign all rights and obligations under a premium finance agreement to another State-registered premium finance company or (2) pledge a premium finance agreement as collateral for a loan.
  - Establishes that a premium finance company that is a party to a premium finance agreement for commercial automobile, fire, or liability insurance is authorized to (1) assign all rights and obligations under a premium finance agreement to another person if the premium finance agreement expressly confers the right to assign all rights and obligations under it or (2) pledge a premium finance agreement as collateral for a loan.

- Provides that in the event the premium finance company assigns the obligation to service a premium finance agreement to another premium finance company, it must provide the insured with (1) notice of the assignment and (2) the third-party premium finance company's contact information. Any such notice must be by first-class mail or, if specified requirements are met, electronic means.

*Effective Date: June 1, 2015*

**SENATE BILL 146 (Chapter 476) – Prelitigation Discovery-Insurance Coverage-Prerequisites for Disclosure**

- Reduces the information a claimant who alleges damages as a result of vehicle accident must provide to an insurer before the insurer is required to disclose the applicable limits of insurance coverage to the claimant.
- Removes the requirement that the claimant provide written documentation of: (1) the claimant's health care bills and any loss of income resulting from the accident, and (2) records of health care treatment for injuries sustained by the claimant because of the accident.
- Removes the requirement that the claim by the estate of an individual or beneficiary of an individual who died as a result of a vehicle accident to provide written documentation of: (1) the amount of economic damages, if any, claimed by each known beneficiary of the decedent, including any amount claimed based on future loss of earnings; (2) the bills for health care treatment of the decedent, if any, resulting from the vehicle accident; (3) the records of health care treatment for injuries to the decedent caused by the vehicle accident; and (4) the decedent's past loss of income, if any, resulting from the vehicle accident.
- Removes the provision requiring that the amount of health care bills and loss of income documented by a personal injury claimant total at least \$12,500 in order for the insurer to be required to disclose in writing the applicable limits in each written agreement.

*Effective Date: October 1, 2015*

**SENATE BILL 465 (Chapter 36) – Chesapeake Employers' Insurance Company**

- Authorizes Chesapeake to establish, own, or control a subsidiary for any lawful purpose if the subsidiary: (1) is, or after acquisition will be, wholly owned by Chesapeake; (2) engages in a business activity that is ancillary to the workers' compensation insurance business; and (3) is operated for the purposes of benefiting Chesapeake.
- Requires that two of the board's nine members must be appointed by the Governor. The other seven members must be selected by policyholders under the procedures required by the board's bylaws. The Governor may only remove a member of the board for incompetence or misconduct if that member was appointed by the Governor; however,

the policyholders may remove a member appointed by the policyholders at any time, with or without cause, by majority vote.

- Authorizes the Insurance Commissioner to remove a board member appointed by the policyholders for misconduct, incompetence, or malfeasance after notice and opportunity for a hearing. Board members are no longer required to take the oath required by the Maryland Constitution. The bill specifies the appointment dates and term limits of board members through 2029.
- Outlines future changes as follows:
  - Effective January 1, 2023, that Chesapeake is no longer exempt from Title 11 of the Insurance Article, which regulates insurance rates and ratemaking procedures and Chesapeake must join the rating organization chosen by the Insurance Commissioner and follow all reporting and ratemaking requirements in the same manner as all other workers' compensation insurers in the State.
  - On or before October 1, 2016, and each following year through October 1, 2022, the rating organization, in consultation with Chesapeake, must submit a report to the Senate Finance Committee and the House Economic Matters Committee on the progress that Chesapeake has made in preparing to become a member of the rating organization.
  - Effective January 1, 2022, the rating organization must create and maintain an exception in its occupation classification system to allow any authorized insurer in the State to use a single classification code for governmental occupations that are not already included in police, firefighter, and clerical classifications.
- Requires the Commissioner to review the State's self-insured workers' compensation program at least once every five years and submit a report to the State Treasurer.

***Effective Date:***            ***October 1, 2015***

**SENATE BILL 553 (Chapter 39) – Motor Clubs – Scope of Law – Fees**

- Clarifies that the provisions that govern motor clubs do not apply to a motor vehicle manufacturer or distributor or a wholly owned subsidiary that sells, furnishes, or procures emergency road service, towing service, or other service that may be offered by a licensed motor club as part of a mechanical repair contract.
- Clarifies that the provisions that govern motor clubs do not apply to a licensed vehicle dealer or any person that sells, furnishes, or procures emergency road service, towing service, or other service that may be offered by a licensed motor club as part of a mechanical repair contract only if the provider of services maintains adequate insurance reserves as defined by the Commissioner and the mechanical repair contract is offered in compliance with State law.

- Expands the definition of emergency road service to include the replacement of a vehicle key or key fob that becomes inoperable or is lost or stolen.
- Clarifies that the fees to be charged the motor club member be filed with the Insurance Commissioner at time of initial and renewal application for licensing of a motor club and provided to motor club members in the service contract.

*Effective Date:           October 1, 2015*

**SENATE BILL 554 (Chapter 362) – Insurance-Reinsurers-Fees**

- Requires certified reinsurers to pay a fee for filing an annual statement with the Commissioner. Also clarifies that accredited reinsurers (formerly known as accepted reinsurers) must pay the fee.
- Specifies the annual filing fee for certified reinsurers and accredited reinsurers is \$1,000.

*Effective Date:           July 1, 2015*

**SENATE BILL 770 (Chapter 51) – Insurance-Motor Vehicle Rental Companies – Limited Lines License to Sell Insurance**

- Permits an authorized representative to perform the same functions, including selling insurance, as the employees of the motor vehicle rental company if the authorized representative meets the same requirements, including training, as the company’s employees who sell, offer, or provide limited lines insurance for rental vehicles.
- Establishes that an employee or authorized representative of a motor vehicle rental company who offers or sells insurance coverage on behalf of the company may be compensated for offering or selling the insurance, but may not be compensated in a manner solely based on the number of customers who purchase rental vehicle insurance.
- Requires a motor vehicle rental company that holds a limited lines license to sell insurance in connection with the rental of a motor vehicle to maintain a register that contains the names of each employee or authorized representative who offers motor vehicle limited lines insurance on behalf of the company, and the business addresses of all locations in the State where employees or authorized representatives offer the insurance. The register is subject to inspection by the Insurance Commissioner.
- Requires an employee or authorized representative to inform a renter that the policy offered by the motor vehicle rental company may duplicate coverage already provided by the renter’s other policies of insurance.

*Effective Date:           July 1, 2015*

**SENATE BILL 868 (Chapter 204) – Public Utilities-Transportation Network Services and For-Hire Transportation**

- Establishes a separate regulatory system for transportation network services that encompasses transportation network companies and transportation network operators, including licensing, criminal history records checks, and insurance requirements. The insurance provision of the bill are as follows:
- Requires a transportation network operator, a transportation network company on the behalf of the transportation network operator, or a combination of both to maintain primary motor vehicle insurance that recognizes that the individual is a transportation network operator or otherwise uses a motor vehicle to transport passengers for hire and that covers the operator while the operator is providing transportation network services.
- Requires the insurance, while an operator is providing transportation network services, to provide security of at least: (1) for the payment of claims for bodily injury or death arising from an accident, up to \$50,000 for any one person and up to \$100,000 for any two or more persons, in addition to interest and costs; and (2) for the payment of claims for property of others damaged or destroyed in an accident, up to \$25,000, in addition to interest and costs.
- Requires the insurance to also provide uninsured motorist coverage and personal injury protection coverage as required under current law.
- Provides that an insurance policy that meets the requirements described above is deemed to satisfy the financial responsibility requirement for a motor vehicle as specified in current law.
- Requires the insurance maintained by a transportation network company to provide the required coverage from the first dollar of a claim and provide for the defense of a claim in the event that the insurance maintained by a transportation network operator has coverage that has canceled or has lapsed or is otherwise not in force.
- Requires a transportation network company to: (1) verify that the required coverage is maintained at all times, and (2) provide to PSC and the Insurance Commissioner specified records and information related to the insurance coverage annually upon each renewal.
- Establishes that the required insurance must be issued by: (1) an insurer authorized to do business in the State, or (2) solely with respect to insurance maintained by a transportation network company, an eligible surplus lines insurer having an A.M. Best financial strength rating of A- or better.
- Requires the company to disclose to the operator, before the operator may accept a request for a ride made through the transportation network company's digital network, in writing: (1) the insurance coverage, including the types of coverage and the limits for each coverage that the transportation network company provides while the operator is providing transportation network services; (2) that the operator should contact the



operator's personal motor vehicle insurer or agent to advise the insurer or agent that the operator will be providing transportation network services and to determine the coverage, if any, that may be available from the operator's personal motor vehicle policy; and (3) that, if the motor vehicle that the operator uses to provide transportation network services has a lien against it, using the motor vehicle for transportation network services without physical damage coverage may violate the terms of the contract with the lienholder.

- Requires that, if an accident occurs that involves a motor vehicle that is being used to provide transportation network services, the operator must provide proof of satisfactory insurance and disclose whether the accident occurred while the operator was providing transportation network services.
- Establishes that, in a claim coverage investigation following an accident, a transportation network company and any insurer potentially providing coverage as authorized in the bill must cooperate to facilitate the exchange of information with directly involved parties and any insurer of an operator, if applicable, including: (1) the precise times that an operator was logged onto the transportation network company's digital network within 12 hours of the accident, and (2) a clear description of the coverage, exclusions, and limits provided under any motor vehicle insurance maintained for transportation network services.
- Specifies that an authorized insurer that writes motor vehicle liability insurance in the State may exclude any and all coverage and the duty to defend afforded under an owner's or operator's personal motor vehicle insurance policy for any loss or injury that occurs while the vehicle operator is providing transportation network services.
- Provides that, if a motor vehicle insurer intends to exclude coverage for transportation network services, it must provide a written notice to the named insured stating that the policy excludes coverage at time of issuance if the policy is issued after January 1, 2016, or at the first renewal after January 1, 2016, for in-force policies.
- Requires that a motor vehicle insurer that defends or indemnifies a claim against a driver for which coverage is excluded under the terms of its policy must have a right of contribution against other insurers that provide insurance to the same driver in satisfaction of the requirements for transportation network services established by the bill at the time of the loss.
- Requires the MIA to conduct a study on: (1) the availability of the insurance requirements specified in the bill for the transportation network industry offered by insurers admitted in the State; (2) the methods to increase the availability of such coverages by admitted carriers; and (3) the affordability of such coverages. The MIA must report its findings and recommendations to the Senate Finance Committee and the House Economic Matters Committee by November 1, 2016.
- Requires the Insurance Commissioner, beginning July 1, 2017, and annually thereafter through July 1, 2021, to make a determination whether, with regard to the insurance requirements specified in the bill, there is a viable, affordable, and adequate market of

admitted carriers in the State available to provide the required coverages to the transportation network services industry.

*Effective Date: July 1, 2015*

**SENATE BILL 910 (Chapter 208) – Motor Vehicle Insurance-Entry Level Commercial Truck Drivers’ License Holders-Study**

- Requires the Department of Labor, Licensing, and Regulation (“DLLR”) to conduct a study of the availability, accessibility, and affordability of commercial motor vehicle insurance for motor carriers who want to employ entry-level commercial driver’s license drivers and to make recommendations on how to make commercial motor vehicle insurance for the motor carriers more available, accessible, and affordable.
- Allows DLLR, in conducting the study, to consult with (1) various State agencies related to insurance and transportation, including MIA; (2) institutions of higher education, entities related to higher education, and training schools; (3) the motor carrier industry; and (4) the motor vehicle insurance industry and producers.
- Requires DLLR, by December 1, 2015, to report its findings to the Senate Finance Committee and House Economic Matters Committee but permits that if DLLR has not completed the study by that date, it may instead report its interim findings and recommendations by December 1, 2015, and report its final findings and recommendations by December 1, 2016.

*Effective Date: June 1, 2015*