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Governor

ANTHONY G. BROWN
Lt. Governor

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BULLETIN 12-18

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 2012 Insurance Legislation Signed into Law by Governor Martin O'Malley**

Date: **September 2012**

This summary is meant to place insurers, non-profit 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 2012 Session and the First Special Session of 2012 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 Maryland Insurance Administration's (MIA's) interpretation of the legislation, nor is it a representation of how the MIA may choose to enforce these new provisions.*** All regulated entities should refer to the Chapter Laws of Maryland for the 2012 Session or the 2012 First Special 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 2012 Session or First Special Session of 2012 by accessing the Maryland General Assembly's web site at http://mlis.state.md.us on the Internet 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 2012 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 2012 insurance legislation, please contact Tinna Damaso Quigley at (410) 468-2202 or tquigley@mdinsurance.state.md.us.

2012 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 243 (Chapter 5) / SENATE BILL 179 (Chapter 4) - Kathleen A. Mathias Chemotherapy Parity Act of 2012

- Prohibits insurers, nonprofit health service plans, and HMOs (HMOs) that provide coverage for cancer chemotherapy from imposing dollar limits or cost-sharing requirements on coverage for orally administered chemotherapy that are less favorable to an insured or enrollee than the dollar limits or cost-sharing requirements that apply to coverage for chemotherapy that is administered intravenously or by injection.

- Restricts insurers, nonprofit health service plans, and HMOs from reclassifying cancer chemotherapy or increasing cost-sharing requirements imposed on chemotherapy to achieve compliance with the Act.

- Inapplicable to a policy or contract that provides the essential health benefits required under the federal Affordable Care Act (ACA).

Effective Date: October 1, 2012

HOUSE BILL 286 (Chapter 75) /SENATE BILL 484 (Chapter 74) - Managed Care Organizations - Medical Loss Ratio Information - Publication

- Requires the Secretary of Health and Mental Hygiene to publish on its website:

  - information about the loss ratio of each managed care organization (MCO) participating in the Medicaid program for each year during the most recent three year period;

  - for each year during the most recent three year period, the amount to be returned to Medicaid, if any, from a MCO for failing to meet their loss ratio requirement of less than 85%; and

  - any amount due to or received by the Department of Health and Mental Hygiene (DHMH) from a MCO for each year during the three year period.

Effective Date: October 1, 2012

HOUSE BILL 443 (Chapter 152) - Maryland Health Benefit Exchange Act of 2012

- Expands the operating structure of the Maryland Health Benefit Exchange established in 2011 such that the primary function of the Exchange is to certify and make available

qualified health plans to individuals and small businesses and to serve as a gateway to an expanded Medicaid program under the ACA.

- Establishes the Small Business Health Options Program (SHOP) Exchange and the Individual Exchange. The SHOP Exchange must be a separate insurance market within the Exchange for small employers.

Market Participation Rules

- Establishes requirements for insurance carriers that want to participate in the individual and small group health insurance markets.

- With some exceptions, prohibits carriers from offering health benefit plans in the small group market unless they also offer qualified health plans (QHPs) in the SHOP Exchange.

- With some exceptions, prohibits carriers from offering health benefit plans in the individual market unless they offer QHPs in the Individual Exchange.

- Requires the Exchange, beginning January 1, 2014, to allow any qualified health plans that meet minimum standards to be offered in the Exchange.

- Authorizes the Exchange to employ alternative contracting options and active purchasing strategies beginning January 1, 2016. Before employing such an option or strategy, the Exchange must submit a plan to specified committees of the General Assembly and allow the committees 90 days for review and comment. Instituting active purchasing options would also negate the current participation requirements for carriers.

- Prohibits the Exchange from requiring Medicaid MCOs to offer QHPs in the Exchange.

SHOP Exchange and Navigator Program

- Requires the SHOP Exchange to allow qualified employers to designate a coverage level within which their employees may choose any QHP, or designate a carrier or insurance holding company system and a menu of QHPs offered by the carrier or insurance holding company system from which their employees may choose.

- Authorizes the SHOP Exchange to allow qualified employers to designate qualified dental plans and qualified vision plans as options for their employees.

- Establishes a SHOP Exchange Navigator Program that is required to focus outreach efforts and provide health insurance enrollment and eligibility services to small employers that do not offer health insurance to their employees already.

- Requires a SHOP Exchange Navigator to hold a SHOP Exchange Navigator license, be engaged by and receive compensation only through the SHOP Exchange, and complete and comply with specified training requirements.

Individual Exchange Navigator Program

- Establishes a Navigator Program for the Individual Exchange that, among other things is required to: (1) focus outreach efforts and services on individuals without health insurance coverage; (2) enable the Individual Exchange to comply with the ACA by providing seamless entry and transition among Medicaid, the Maryland Children's Health Program, and qualified plans; and (3) use Individual Exchange Navigator Entities to provide comprehensive consumer assistance services.

- Requires consumer assistance services to include: (1) education and outreach; (2) information regarding the selection of qualified plans; (3) information regarding assessment of tax implications and premium and cost-sharing requirements, and information regarding application, enrollment, renewal, and disenrollment processes; and (4) facilitating eligibility determinations.

- Requires the Individual Navigator Program to provide information and services in a culturally and linguistically appropriate and accessible manner.

- Defines an Individual Exchange Navigator Entity as a community-based organization or other entity or partnership of entities authorized by the Individual Exchange that employs or engages Individual Exchange navigators.

- Requires services that involve the sale, solicitation, and negotiation of QHPs offered in the Individual Exchange to be provided by an Individual Exchange Navigator or producer authorized to sell in the Individual Exchange.

- Requires an Individual Exchange Navigator to hold a certificate issued by the Individual Exchange. An Individual Exchange Navigator, may be employed or engaged by an Individual Exchange Navigator Entity, and may receive compensation only through the Individual Exchange or through an Individual Exchange Navigator Entity, and meet other requirements.

- Authorizes an Individual Exchange Navigator Entity to employ or engage individuals other than Individual Exchange Navigators to perform limited functions, such as education and outreach.

Insurance Producers

- Requires a licensed insurance producer to register, receive authorization and complete and comply with any specified training requirements before selling QHPs in the SHOP Exchange or Individual Exchange.

- Requires insurance producers authorized to sell plans in the SHOP Exchange to inform small employers of all options available in the SHOP Exchange.

- Requires insurance producers authorized to sell plans in the Individual Exchange to refer individuals seeking insurance who may be eligible for Medicaid or the Maryland Children's Health Program to the Navigator Program for the Individual Exchange.

- Prohibits an insurance producer from being compensated by either Exchange; rather an insurance producer selling a plan in either Exchange must be compensated directly by a carrier.

- Prohibits the Exchange from requiring navigators to hold an insurance producer license.

Certification of Qualified Health Plans and Qualified Vision Plans and Qualified Dental Plans

- Authorizes the Exchange to require a health benefit plan, in order to be certified as a QHP, to include transition of care language in contracts, meet criteria that encourage and support QHPs in facilitating cross-border enrollment, and demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008.

- Allows the Exchange to offer qualified dental plans and qualified vision plans.

- Authorizes carriers to offer dental and vision benefits in the Exchange as stand-alone plans, as an endorsement to a medical plan, and/or in conjunction with a medical plan.

- Authorizes the Exchange to determine whether a carrier may elect to include nonessential oral and dental benefits or nonessential vision benefits in a QHP and to determine the standards of disclosure for pricing the benefits.

Essential Health Benefits

- Requires the Maryland Health Care Reform Coordinating Council (MHCRCC) to select the State benchmark plan by September 30, 2012.

- Requires the MHCRCC to determine the 10 health benefit plans deemed eligible by the U.S. Secretary of Health and Human Services to be the benchmark plan, conduct a comparative analysis of the benefits of each plan, solicit the input of stakeholders and the public, and select a plan that complies with all requirements of specified State and federal laws.

Transitional Reinsurance, Risk Adjustment, and Risk Corridors

- Requires the Exchange, with the approval of the Commissioner, to implement or oversee the implementation of ACA requirements relating to transitional reinsurance and risk adjustment.

- Prohibits the Exchange from assuming responsibility for the program of risk corridors for health benefit plans in the Individual and SHOP exchanges.

- Requires the Exchange to operate or oversee a transitional reinsurance program for coverage years 2014 through 2016 in consultation with the Maryland Health Care Commission (MHCC) and with the approval of the Commissioner.

- Requires the Exchange, with the approval of the Commissioner, to operate or oversee the operation of a risk adjustment program.

- Requires the Exchange, beginning in 2014, with the approval of the Commissioner, to strongly consider using the federal model adopted by the U.S. Secretary of Health and Human Services in the operation of the State's risk adjustment program.

Fraud, Waste, and Abuse Detection and Prevention

- Requires the Exchange to establish a full-scale fraud, waste, and abuse detection and prevention program.

Regulations and Interim Policies

- Requires the Exchange Board to submit proposed regulations to specified committees of the General Assembly at least 30 days prior to submitting any proposed regulation to the *Maryland Register* unless this requirement is waived by the committee chairs.

- Authorizes the Exchange Board to adopt interim policies, pending adoption of regulations, if necessary to comply with federal law and regulations and to allow carriers offering qualified plans sufficient time to design and develop such plans and file rates.

Uncodified Study and Reporting Requirements

- Requires a joint legislative and executive committee to conduct a study and report its findings and recommendations on the financing mechanisms that should be used to enable the Exchange to be self-sustaining by 2015, including recommendations on the specific mechanisms that should be used to finance the Exchange for consideration by the General Assembly during the 2013 session.

- Establishes study and reporting requirements concerning the development of risk adjustment and reinsurance programs, the establishment of continuity of care requirements in the State's health insurance markets, whether the Exchange should remain an independent public body, and whether to continue to maintain, within the Exchange, separate small group and individual markets or to merge the two markets.

Effective Date: ***June 1, 2012***

HOUSE BILL 465 (Chapter 514)/ SENATE BILL 456 (Chapter 513) - Health Insurance - Health Benefit Plan Premium Rate Review

- Clarifies and codifies the rate filing and approval process for health insurance carriers by applying the same review standards to rate filings for health benefit plans of insurers, nonprofit health service plans, and HMOs.

- Extends to out of state association plans with certificates of authority issued in Maryland the current requirement that an insurer, nonprofit health service plan, and HMO file for approval from the Commissioner a premium rate or change to a premium rate charged.

- Provides the factors that the Commissioner is required to consider when reviewing a rate filing, to the extent appropriate, including past and prospective loss experience within and outside the State, underwriting practice and judgment, a reasonable margin for reserve needs, past and prospective expenses both countrywide and those specifically applicable to the State, and any other relevant factors within and outside the State.

- Requires the Commissioner to disapprove or modify a proposed premium rate filing if the proposed premium rates appear, based on statistical analysis and reasonable assumptions, to be inadequate, unfairly discriminatory, or excessive in relation to benefits.

- Provides that each proposed rate and any supporting information filed must be open to public inspection. A carrier may, however, request a finding by the Commissioner that certain information included in a rate filing be considered confidential commercial information and not subject to public inspection.

Effective Date: ***July 1, 2012***

HOUSE BILL 470 (Chapter 535) /SENATE BILL 540 (Chapter 534) - Maryland Health Care Commission - Preauthorization of Health Care Services - Benchmarks

- Requires the MHCC to work with specified health care payors (insurers, nonprofit health service plans, HMOs, pharmacy benefit managers) and providers to attain benchmarks for standardizing and automating the process required by payors for preauthorizing health care services.

- Establishes dates by which benchmarks must be met and requires MHCC to establish by regulation a process for waiving a payor or provider from the benchmarks for extenuating circumstances.

- Requires payors to establish an online preauthorization system by July 2013, and by July 2015, providers must use either the online preauthorization system, or an alternative system that meets a national transaction standard, if established and adopted by the health care industry.

- Requires the MHCC to establish a process for payors and providers to obtain a waiver from attaining benchmarks.

Effective Date: ***June 1, 2012***

HOUSE BILL 838 (Chapter 319) / SENATE BILL 903 (Chapter 318) - Health Insurance - Pharmacy Benefits Managers - Audits and Reimbursement of Pharmacies or Pharmacists

- Modifies and expands provisions governing audits and reimbursement of pharmacies and pharmacists by a pharmacy benefits manager (PBM). The provisions include when a PBM may recoup by setoff any monies for overpayment or denial of a claim and the circumstances under which a PBM may retroactively deny or modify reimbursement to a pharmacy or pharmacist for a claim that has been approved by a PBM.

- With the exception of overpayments, prohibits a PBM from retroactively denying or modifying reimbursement for a claim previously approved by the PBM unless the claim was fraudulent, the pharmacy or pharmacist had been reimbursed for the claim previously, the services reimbursed were not rendered by the pharmacy or pharmacist, or the claim otherwise caused monetary loss to the PBM if the PBM allowed the pharmacy a reasonable opportunity to remedy the cause of the loss.

- Authorizes the Commissioner to adopt regulations regarding the documentation that may be requested during an audit and the process a PBM may use to conduct an audit.

Effective Date: ***October 1, 2012***

HOUSE BILL 982 (Chapter 623) / SENATE BILL 928 (Chapter 622) - Health Insurance - Fees for Administrative Services Provided by Insurance Producers - Authorized

- Defines "administrative service" to mean a service, other than a service related to the sale, solicitation, negotiation, or servicing of a health benefit plan, that an insurance producer provides to assist an employer in (1) complying with a statutory or regulatory requirement; (2) providing an employee benefit on behalf of the employer; or (3) performing functions related to the management of employees of the employer.

- Authorizes an insurance producer who is licensed to sell health insurance to charge reasonable fees for an administrative service that is sold to an employer.

- Prohibits the charging of administrative service fees for services that are compensated by commissions or other compensation paid by an insurer, nonprofit health service plan or HMO related to a health benefit plan.

- Prohibits the charging of administrative service fees for services that are performed by the insurance producer acting as a third-party administrator or an insurance adviser.

- Requires an insurance producer to disclose specified information regarding the administrative services provided and the fees associated with the services.

Effective Date: ***October 1, 2012***

HOUSE BILL 1055 (Chapter 294) / SENATE BILL 744 (Chapter 293) - Health Insurance - Habilitative Services - Required Coverage, Workgroup, and Technical Advisory Group

- Clarifies the definition of a "congenital or genetic birth defect" to include intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities.

- Requires the Commissioner to establish a workgroup on access to habilitative services benefits.

- Requires DHMH, in consultation with the Maryland Insurance Commissioner, to establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

- Requires the Commissioner to adopt regulations based on the recommendations of the technical advisory group and, beginning on November 1, 2013, requires insurers, nonprofit health service plans and HMOs to make coverage determinations relating to the treatment of autism and spectrum disorders in accordance with the regulations.

Effective Date: ***July 1, 2012***

HOUSE BILL 1149 (Chapter 580) / SENATE BILL 781 (Chapter 579) - Health Insurance - Coverage for Services Delivered Through Telemedicine

- Defines telemedicine as the use of interactive audio, video, or other telecommunications or electronic technology. Telemedicine service does not include an audio-only telephone conversation between a health care provider and a patient, an electronic mail message between a health care provider and a patient, or a facsimile transmission between a health care provider and a patient.

- Requires insurers, nonprofit health service plans and HMOs ("carriers") to provide coverage under a health insurance policy or contract for health care services appropriately delivered through telemedicine and not exclude from coverage a health care service solely because it was provided through telemedicine.

- Requires carriers to reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately provided through telemedicine.

- Authorizes carriers to undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered in-person or through telemedicine if the appropriateness of the service to be delivered through telemedicine is determined in the same manner as a service that is not delivered through telemedicine.

- Requires DHMH to study and report on issues relating to telemedicine including its use in delivering services to inmates in correctional facilities and to enrollees in the Medicaid program.

Effective Date: ***October 1, 2012***

HOUSE BILL 1340 (Chapter 634) / SENATE BILL 1003 (Chapter 633) - <u>Life and Health Insurance Guaranty Corporation Act - Revisions</u>

- Clarifies that, subject to certain limitations, the purpose of the Life and Health Insurance Guaranty Corporation Act of 1970 (Guaranty Corporation Act) is to protect specified policy owners, contract owners, certificate holders, beneficiaries, payees, and assignees of specified life insurance policies, health insurance policies, annuity contracts, and supplemental contracts against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer that issued the policies or contracts.

- For specified policies or contracts other than structured settlement annuities, requires coverage to extend to a person that is a resident and an owner of or certificate holder under the policy or contract. Coverage also extends to certain nonresident owners under the policy or contract. Extends coverage to a beneficiary, assignee, or payee of a covered person regardless of the person's residence for specified policies or contracts.

- Extends coverage, with specified exceptions, to a person who is a payee or beneficiary of the payee, if the payee is deceased, under a structured settlement annuity under certain circumstances.

- Provides that the principal place of business for a plan sponsor or person other than an individual is the single state in which the individuals who establish policy for the direction, control, and coordination of the operations of the entity primarily exercise that function.

- Clarifies the Life and Health Insurance Guaranty Corporation's (Corporation) authority to take certain action for member insurers that are impaired or insolvent.

- Authorizes the Corporation, subject to approval by the Commissioner, to substitute coverage for policies and contracts under specified circumstances.

- Alters the maximum amounts of contractual obligations of impaired or insolvent insurers for which the Corporation may become liable in the following manner:
    - with respect to health insurance:
        - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans;
        - $300,000 for disability insurance; and
        - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above;
    - with respect to annuities:
        - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values; and
        - with respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values; and
    - the maximum amount of protection for each individual, regardless of the number of policies or contracts is:
        - $300,000 in the aggregate for all types of coverage for life insurance, health insurance, and annuities with the exception of basic hospital, medical, and surgical insurance or major medical insurance; and
        - $500,000 in the aggregate for basic hospital, medical, and surgical insurance or major medical insurance.
- Authorizes the Corporation to join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the Corporation.
- Extends immunity from liability for any action or omission taken by the Corporation as a participant in an organization of one or more other state associations of similar purposes and the agents or employees of such an organization in which the Corporation is a participant.

Effective Date: ***October 1, 2012***

HOUSE BILL 1356 (Chapter 720) - <u>Health Insurance - Dental Preventive Care - Coverage</u>

- Establishes requirements for coverage of dental preventive care – a preventive dental visit, screening, oral examination, teeth cleaning, fluoride treatment, or routine preventive service – that is a covered benefit under a policy or contract issued by an insurer, nonprofit health service plan, HMO or dental plan organization ("carriers").

- If a carrier provides dental preventive care under a policy or contract and all other requirements for the coverage of dental preventive care are met, requires a carrier to provide coverage for dental preventive care:

    - at any time during the plan year for a policy that covers one visit a year; and

    - if the policy or contract provides coverage for dental preventive care more than once during the plan year, prohibits the carrier from setting the frequency limitation on dental preventive care to an interval greater than 120 days.

Effective Date: ***October 1, 2012***

SENATE BILL 77 (Chapter 171) - <u>Life Insurance and Annuities - Unfair Claim Settlement Practices - Failure to Search Death Master File</u>

- Requires an insurer that issues, delivers, or renews a policy of life insurance or an annuity contract in the State to perform, at least semiannually, a good-faith comparison of the insurer's in-force life insurance policies, annuity contracts, and retained asset accounts against the most recent Death Master File maintained by the Social Security Administration or another database or service that is at least as comprehensive as the Social Security Administration's Death Master File.

- If a comparison results in a match with an insured, annuitant, or retained asset account holder, requires an insurer, within 90 days, to make a good-faith effort to confirm the death of the insured, annuitant, or retained asset account holder and locate any beneficiaries, if benefits are due.

- Authorizes an insurer to disclose the minimum necessary personal information about an insured, annuitant, account holder, or beneficiary to a person that may be able to assist in locating a beneficiary.

- Prohibits an insurer from charging for any fees or costs incurred in performing the comparison against the Death Master File, confirming the death of the insured, annuitant or retained asset account holder or locating the beneficiary of the insured, annuitant or retained asset account holder.

- Provides that a failure to comply with the Act's requirements is an unfair claim settlement practice.

Effective Date: ***October 1, 2013***

SENATE BILL 121 (Chapter 27) - Senior Prescription Drug Assistance Program – Sunset Extension

- Extends until the end of December 31, 2014, the termination date of the Senior Prescription Drug Assistance Program; and lengthens the period of time during which the subsidy required under the Senior Prescription Drug Assistance Program may not exceed $14,000,000.

Effective Date: ***October 1, 2012***

SENATE BILL 227 (Chapter 195) - Maryland Health Care Commission - Assessment of Fees and Maryland Trauma Physician Services Fund - Revisions

- Repeals the requirement that the Commissioner, by May 30 of each year, notify the MHCC of the total premiums earned in the State for health benefit plans sold by health insurers, nonprofit health service plans, and HMOs.

- Alters the manner in which the MHCC calculates user fees assessed from premiums earned to premiums written.

- Repeals the limitation that expenditures from the Maryland Trauma Physician Services Fund not exceed fund revenues in that fiscal year.

Effective Date: ***July 1, 2012***

SENATE BILL 954 (Chapter 326) - Medical Records - Enhancement or Coordination of Patient Care

- Authorizes specific medical information or medical data contained in an individual's medical or claims records to be disclosed to the individual's treating provider or to the individual's insurer, nonprofit health service plan or HMO ("carriers") or accountable care organization (ACO) for the sole purpose of enhancing or coordinating patient care or assisting the treating provider's clinical decision making.

- Authorizes a disclosure for the stated purpose to occur if the disclosure is made in accordance with statutory limitations on disclosure of mental health records, the federal Health Insurance Portability and Accountability Act of 1996, any other applicable

federal privacy laws, and any other applicable statutory requirements for disclosures made through a health information exchange.

- Prohibits a disclosure from being used for underwriting or utilization review purposes.
- Requires carriers, ACOs, and health care providers to provide a specific notice regarding information to be shared, with whom it will be shared, and the specific types of uses and disclosures that may be made.
- Requires the notice to include an opportunity for an individual to opt-out of the sharing of the individual's medical record.

Effective Date: ***October 1, 2012***

PROPERTY AND CASUALTY

HOUSE BILL 65 (Chapter 11) / SENATE BILL 30 (Chapter 10) - Injured Workers' Insurance Fund - Cancellation of Policies - Failure to Pay a Premium

- Aligns the Injured Workers' Compensation Fund's (IWIF) cancellation procedures with those of private workers compensation insurers by authorizing IWIF to cancel policies in accordance with the Insurance Article.
- Authorizes IWIF to pursue collection of the debt of any policyholder whose insurance is cancelled for nonpayment of premium, rather than referring cases for collection to the Attorney General.

Effective Date: ***July 1, 2012***

HOUSE BILL 114 (Chapter 41) / SENATE BILL 174 (Chapter 40) - Subsequent Injury Fund and Uninsured Employers' Fund - Assessments on Settlement Agreements

- Excludes the amount of medical benefits in a formal set-aside allocation that is part of an approved settlement agreement approved by the Workers' Compensation Commission (WCC) from the assessments required to be imposed by the WCC payable to the Subsequent Injury Fund and the Uninsured Employers' Fund if: (1) the amount of the medical benefits exceeds $50,000 and the payment of the benefits by the employer or its insurer is made directly to an authorized insurer that provides periodic payments to the covered employee pursuant to a single premium authority; or (2) the amount of medical benefits is in any amount and the payment of medical benefits by the employer or its insurer is to an independent third-party administrator that controls and pays the medical services in accordance with the formal set-aside allocation, provided there is no reversionary interest to the covered employee or the covered employee's beneficiaries.

Effective Date: ***July 1, 2012***

HOUSE BILL 149 (Chapter 211) / SENATE BILL 309 (Chapter 210) - Mopeds and Motor Scooters - Titling, Insurance, and Required Use of Protective Headgear

- Requires mopeds and motor scooters to be titled and requires an excise tax to be imposed on any moped or motor scooter for which sales and use tax is not collected at the time of purchase.
- Requires the operator of a moped or a motor scooter to carry a vehicle liability insurance policy and to possess proof of this insurance when operating a moped or motor scooter.
- Expands the definition of a "covered vehicle," for which the Maryland Automobile Insurance Fund (MAIF) is required to provide insurance coverage to eligible individuals, to include mopeds, motor scooters, and any motor vehicle required to be registered with the Motor Vehicle Administration (MVA).
- Requires an individual who rides or operates a motor scooter or moped to wear protective headgear and, if the vehicle does not have a windscreen, an eye-protection device.
- Authorizes an insurer either to exclude certain economic loss benefits from personal injury protection coverage of policies written for mopeds or motor scooters or to offer the economic loss benefits with deductibles, options, or specific exclusions, as is authorized under current law for motorcycles.
- Requires the MVA to waive the fee for titling a moped or motor scooter for an individual who owns the moped or motor scooter on October 1, 2012, and titles the vehicle during the first year that the law is in effect.

Effective Date: ***October 1, 2012***

HOUSE BILL 293 (Chapter 119) – Worker's Compensation - Uninsured Employers' Fund

- Specifies that the director of the Uninsured Employers' Fund (UEF), rather than the UEF board, is the appointing authority for all staff and has immediate supervision and direction over administration of UEF.
- Authorizes the director to employ staff in accordance with the State budget.
- Requires the UEF board to review the administration of the UEF fund by the director.
- Authorizes an employee to appeal to the board a disciplinary action taken by the director.

Effective Date: ***October 1, 2012***

HOUSE BILL 421 (Chapter 663) – Workers' Compensation - Death Benefits - Determination of Benefits

- Alters the calculation of workers' compensation benefits for a dependent of a deceased covered employee who died due to an occupational disease by calculating the average weekly wage using the date of the last injurious exposure of the covered employee to the hazards of the occupational disease, rather than from the date of disablement from the occupational disease.

Effective Date: October 1, 2012

HOUSE BILL 463 (Chapter 480) / SENATE BILL 297 (Chapter 479) - Property and Casualty Insurance - Certificates of Insurance and Certificate of Insurance Forms

- Requires a certificate of insurance form to be filed with and approved by Commissioner.

- Requires the Commissioner to disapprove a certificate of insurance form if the form is unjust, unfair, misleading, or deceptive or violates public policy; fails to comply with the requirements specified in the bills; or violates any law or any regulation adopted by the Commissioner.

- Provides that a standard certificate of insurance form adopted by the Association for Cooperative Operations Research and Development or the Insurance Services Office that otherwise complies with the requirements of the Act is considered to be approved by the Commissioner.

- Authorizes the Commissioner to designate a certificate of insurance form required by a federal agency as deemed approved.

- Prohibits a person from altering or modifying an approved certificate of insurance.

- Requires the Commissioner to adopt regulations to carry out the statutory provisions governing certificates of insurance, including regulations that establish an approval process for certificate of insurance forms.

Effective Date: October 1, 2012

HOUSE BILL 472 (Chapter 373) - Workgroup on Lead Liability Protection for Rental Property

- Requires the Commissioner to convene a workgroup to evaluate and make recommendations relating to lead liability protection for owners of rental property built before 1978 and to report the findings and recommendations of the workgroup to the Governor and General Assembly by December 1, 2012.

Effective Date: ***June 1, 2012***

HOUSE BILL 573 (Chapter 383) - Criminal Procedure - Bail Bondsman Solicitation - Penalty

- Adds an employee of a courthouse or an employee of a correctional facility to the statutory prohibition against solicitation by a bail bondsman and clarifies that the statutory prohibition applies to approaching, enticing, or inviting a person to use the services of a specific bail bondsman.

- Increases the fines for the offense of solicitation such that first-time offenders are subject to a maximum fine of $2,500 and subsequent offenders are subject to a maximum fine of $5,000. Additionally, violators are subject to a 30-day license suspension for a first-time offense if licensed under the Insurance Article and a 90-day license suspension for subsequent violations if licensed under the Insurance Article.

Effective Date: ***October 1, 2012***

HOUSE BILL 715 (Chapter 269) / SENATE BILL 604 (Chapter 268) - Motor Vehicle Insurance - Uninsured Motorist Coverage - Effect of Consent to Offer of Settlement

- Provides that written acceptance by an uninsured motorist insurer of a settlement offer under § 19-511(b)(1) of the Insurance Article: (1) may not be construed to limit the right of the uninsured motorist insurer to raise any issue relating to liability or damages in an action against the uninsured motorist insurer; (2) does not constitute an admission by the uninsured motorist insurer as to any issue raised in an action against the uninsured motorist insurer.

Effective Date: ***October 1, 2012***

HOUSE BILL 742 (Chapter 244) / SENATE BILL 489 (Chapter 243) - Bail Bondsmen - Acceptance of Installment Contracts

- Clarifies that a bail bondsman may accept installment payments for a bail bond premium.

- If a bail bondsman agrees to accept installment payments, the bill requires the bail bondsman to: (1) include specified information in the installment agreement; (2) secure a signed affidavit of surety by the defendant or the insurer containing the same information included in the installment agreement and provide it to the court; (3) take all necessary steps, including any debt collection remedies provided by law, to collect the total amount owed; (4) keep and maintain records of all collection attempts, installments agreements and affidavits of surety; and (5) certify each year to the Commissioner that the maintained records are accurate and true.

- Requires the installment agreement and signed affidavit of surety to include: (1) the total amount of the premium owed; (2) the amount of any down payment; (3) the balance amount owed to the bail bondsman or the bail bondsman's insurer; (4) the amount and due date of each installment payment; and (5) the total number of installment payments required to pay the amount due.

- Requires a bail bondsman to keep and maintain the records required under the Act in an office that is generally accessible to the public during normal business hours and to make the records available for inspection by the Commissioner.

Effective Date: ***October 1, 2012***

HOUSE BILL 835 (Chapter 398) - Workers' Compensation - Permanent Partial Disability Benefits - Washington Metropolitan Area Transit Authority

- Provides that police officers employed by the Washington Metropolitan Area Transit Authority (WMATA), like other police officers, are eligible for enhanced workers' compensation benefits for permanent partial disabilities.

- Requires WMATA to compensate WMATA police officers who are awarded claims of fewer than 75 weeks for permanent partial disabilities at the higher rate (two-thirds of the officer's average weekly wage, not to exceed one-third of the State average weekly wage) that is established for claims of 75 to 250 weeks.

Effective Date: ***October 1, 2012***

HOUSE BILL 866 (Chapter 683) – Title Insurance-Closing or Settlement Protection-Study

- Requires the Commissioner to: (1) study closing or settlement protection practices of the title insurance industry; and (2) make recommendations for changes to the practices.

- Provides that the Commissioner, in conducting the study, may consult with any person or entity that the Commissioner determines appropriate, and must consider: (1) title insurance producer defalcations (fund misappropriations) reported to the MIA by title insurers; (2) title insurance producer defalcations discovered by the MIA as a result of a

complaint received by the MIA; (3) the extent to which any regulations relating to the onsite review by title insurers of their appointed title insurance producers have addressed the problem of title insurance producer defalcations; (4) the availability and affordability of fidelity bonds, escrow bonds, reinsurance, or other coverage to protect title insurers against the theft, misappropriation, or misuse of closing or settlement funds by their appointed title insurance producers, other agents, or employees; (5) the manner in which closing or settlement protection is being addressed by other states, the National Association of Insurance Commissioners, and the National Coalition of Insurance Legislators; and (6) any other relevant matter, as determined by the Commissioner.

- The Commissioner must report the findings and recommendations of the study to specified legislative committees by December 1, 2012.

Effective Date: ***July 1, 2012***

HOUSE BILL 876 (Chapter 473) / SENATE BILL 256 (Chapter 472) - <u>Property and Casualty Insurance - Commercial Policies - Notices of Premium Increases</u>

- Exempts insurers that issue policies of commercial insurance and workers' compensation insurance from the requirement to send a notice to the named insured and any insurance producer regarding a premium increase if the renewal policy premium is: (1) in excess of $1,000; and (2) an increase over the expiring policy premium of the lesser of 3% or $300.

Effective Date: ***October 1, 2012***

HOUSE BILL 885 (Chapter 300) / SENATE BILL 764 (Chapter 299) – <u>Fraudulent Insurance Acts - Individual Sureties - Contracts of Surety Insurance</u>

- Specifies that, with certain exceptions, it is a fraudulent insurance act for an individual surety to solicit or issue a surety bond or contract of surety insurance.

- Defines "individual surety" as a person who issues surety bonds or contracts of surety insurance and who does not have a certificate of authority issued by the Commissioner.

- Requires the MIA to conduct an analysis of the practices of corporate sureties and individual sureties in the State. In its analysis, the MIA must consider the possibility of licensing individual sureties, the current state of the individual surety market, the regulation of individual sureties in other states, the adequacy of current State law, and the existence of any programs that enhance the availability of surety bonds or contracts of surety insurance for specified businesses.

- Requires the MIA to submit an interim report on its findings and recommendations to specified legislative committees by December 1, 2012, and a final report to the committees by December 1, 2013.

Effective Date: ***June 1, 2012***

HOUSE BILL 1017 (Chapter 408) – Task Force to Study Maryland Insurance of Last Resort Programs

- Establishes the Task Force to Study Maryland Insurance of Last Resort Programs (Task Force) to study: (1) potential benefits to the State from the affiliation of one or more of the State-created insurers of last resort; (2) potential legal and corporate structures for such an affiliation, including whether the affiliation should be accomplished through a holding company structure; (3) the extent to which the affiliation would support or impair each entity in performing its statutory duties; (4) whether each entity should retain a separate existence with its own board of directors or governing committees; (5) the extent to which an affiliation would affect the State's ability to regulate the entities in terms of solvency, rates, and market conduct; (6) the extent to which an affiliation would affect the financial condition of any of the entities and whether safeguards are necessary to protect policyholders and other stakeholders; (7) whether or not each entity should be financially independent and the extent of each entity's responsibility, if any, for the debts and liabilities of the other entities; (8) the tax status of the affiliated entity and the effect of the affiliation on the tax status of each entity with respect to federal, State, and local taxation; (9) whether the Joint Insurance Association should become an authorized insurer with a broader mandate; (10) whether MAIF should be converted into a statutorily created, private, nonprofit, nonstock insurer for automobile and other forms of insurance; (11) whether and under what circumstances any subsidiaries should be permitted to issue dividends; and (12) any other relevant issues or considerations identified by the task force.

- Requires the Task Force to report its preliminary findings to specified legislative committees by December 1, 2012, and its final findings and recommendations, including proposed legislation, by December 1, 2013.

Effective Date: ***May 2, 2012***

HOUSE BILL 1059 (Chapter 627) / SENATE BILL 938 (Chapter 626) – Personal Automobile Insurance - Rescission of Policy or Binder - Authorized

- Authorizes an insurer, under certain specified circumstances, to rescind a policy or binder of personal automobile insurance if the initial premium payment for the policy or binder is made by a check or other remittance that is not honored on presentation to the financial institution where the check or other remittance is drawn.

- To rescind a policy or binder, an insurer is required to send immediately or the next business day after receipt of a notice that the check or other remittance was not honored, written notice to the applicant and any secured creditor, by certificate of mail and, if available, by electric means, to the applicant's or secured creditor's last known address.

- Requires the notice sent by the insurer to state that the policy or binder is rescinded as of its proposed effective date because the applicant's check or other remittance was not honored and that no coverage is in effect under the policy or binder.

- Requires an insurer to continue or reinstate a policy or binder without a lapse in coverage if the financial institution failed to honor the check or other remittance in error, or if the applicant or secured creditor pays the initial premium within five business days after the insurer has sent notice that the check or other remittance for the initial premium was dishonored.

- Authorizes an insurer to rescind a policy or binder if the applicant's initial premium payment is not honored only if the insurer has disclosed to the applicant at the time of application that no coverage will be in effect if the initial premium payment is not honored.

Effective Date: ***January 1, 2013***

HOUSE BILL 1068 (Chapter 699) - <u>Homeowner's Insurance - Limitation on Number of Claims Made - Notice</u>

- Requires an insurer that offers homeowner's insurance in the State to provide an applicant or insured with a written notice at the time of application, issuance, and each renewal stating that, in addition to other reasons allowable under Maryland law, the insurer may cancel or refuse to renew coverage on the basis of the number of claims made by the policyholder within the preceding three-year period.

- Requires the notice to state that the cancellation or refusal to renew may be based on: (1) three or more weather-related claims within the preceding three-year period; (2) one or more weather-related claims made within the preceding three-year period if the insurer has provided written notice to the insured for reasonable or customary repairs or replacement specific to the property that the insured failed to make and that, if made, would have prevented the loss; and (3) a change in the physical condition or contents of the property that increases the hazard insured against and that, if present and known to the insurer before issuance of the policy, would have caused the insurer to refuse to issue the policy.

Effective Date: ***October 1, 2012***

HOUSE BILL 1085 (Chapter 507) / SENATE BILL 431 (Chapter 506) – Workers' Compensation - Emergency Responders - Revisions

- Alters the definition of "on duty" to include the performance of a duty assigned to: (1) a member of a fire company appointed as a deputy sheriff under certain provisions of law; or (2) an individual appointed to serve as a member of the fire police in Washington County under a certain provision of law.
- Expands the definition of "volunteer company" to include a volunteer fire police unit.
- Provides that a member of a volunteer fire company who is a covered employee may not be considered a paid covered employee for receiving, as a membership benefit, a yearly stipend for expenses of up to $5,200 to off-set out-of-pocket expenses.
- Prohibits the stipend from being used when determining the average weekly wage of an injured volunteer.

Effective Date: ***October 1, 2012***

HOUSE BILL 1093 (Chapter 602) / SENATE BILL 861 (Chapter 601) - Portable Electronics Insurance

- Permits a vendor of portable electronics that bills and collects a premium from a covered customer for coverage under a policy of portable electronics insurance not to maintain the premium in a segregated account if, along with other specified requirements, the funds received by the vendor from a covered customer for the sale of portable electronics insurance are held in trust by the vendor in a fiduciary capacity for the benefit of the vendor's appointing insurer.
- Requires a vendor to provide clear and conspicuous written notice to a customer if portable electronics insurance coverage is included in the price of the purchase or lease of portable electronics or related services.
- Requires a vendor to submit a sworn application for a limited lines license on the form required by the Commissioner, in addition to meeting other requirements, in order to sell or offer to sell coverage under a policy of portable electronics insurance to a customer.
- Requires a vendor to provide the contact information and any other information requested by the Commissioner for an officer or employee of the vendor who is designated by the vendor as the person responsible for the vendor's compliance with the law.
- Requires a supervising entity to maintain a registry of all vendor locations that are authorized to sell or offer portable electronics insurance coverage in the State. The

registry must be open for inspection and examination within 10 days after a request by the Commissioner.

Effective Date: ***October 1, 2012***

HOUSE BILL 1101 (Chapter 445) - <u>Workers' Compensation - Medical Presumptions and Study</u>

- Alters the list of occupational disease presumptions under workers' compensation law for firefighters and related personnel.
- Increases the minimum service requirement for a covered employee to qualify for specified occupational disease presumptions to 10 years.
- Requires the Department of Legislative Services to contract with a medical expert affiliated with an academic research institution or organization to conduct a study of all types of cancers that are likely to be contracted by firefighters and related personnel in the line of duty.

Effective Date: ***June 1, 2012***

HOUSE BILL 1175 (Chapter 420) - <u>Workers' Compensation- Students in Unpaid Work-Based Learning Experiences Ho. Co. 9-12</u>

- Authorizes the Board of Education in Howard County to waive the requirement that a participating employer reimburse the county for the cost of workers' compensation insurance coverage provided for students placed in unpaid work-based learning experiences.

Effective Date: ***July 1, 2012***

HOUSE BILL 1180 (Chapter 421) – <u>Vehicle Laws - Required Security - Electronic Reporting Requirements</u>

- Requires an insurer or other provider of required vehicle security to immediately notify MVA electronically of the issuance of new motor vehicle insurance policies and of terminations or other lapses in coverage.
- Requires, for fleet policies, an insurer or provider of required security to electronically notify MVA every 30 days of any additions, deletions, or modifications to the fleet policy, including the policy numbers affected.

Effective Date: ***October 1, 2012***

SENATE BILL 82 (Chapter 460) – Maryland Automobile Insurance Fund - Claims for Bodily Injury or Death - Payment Limitation

- Increases the maximum amount the MAIF Uninsured Division is authorized to pay on authorized unsatisfied claims arising from an injury or death of one individual from $20,000 to $30,000 and from $40,000 to $60,000 for injury or death of more than one individual, exclusive of interest and costs.

- Increases the amount allocated to MAIF from fines levied by the MVA against uninsured drivers beginning in fiscal 2014.

Effective Date: ***October 1, 2012***

SENATE BILL 230 (Chapter 196) - Insurance - Maryland Health Care Provider Rate Stabilization Fund

- Requires a medical professional liability insurer seeking reimbursement from the Rate Stabilization Account on behalf of a health care provider to apply for reimbursement to the Rate Stabilization Account on or before September 30, 2012.

- Requires DHMH rather than the MIA to report annually to the Legislative Policy Committee on the amount of money distributed to Medicaid and the amount of increase in rates for both fee-for-service providers and MCOs.

- Repeals the requirement for an annual audit of the information submitted by medical professional liability insurers applying for reimbursement.

- Repeals the requirement that the Office of Legislative Audits conduct an annual audit of the Rate Stabilization Fund.

Effective Date: ***July 1, 2012***

SENATE BILL 531 (Chapter 253) – Property and Casualty Insurance - Underwriting Period - Discovery of Material Risk Factor

- Requires an insurer that discovers a material risk factor during the 45-day underwriting period to recalculate the binder or policy premium based on the material risk factor if the risk continues to meet the underwriting standards of the insurer in accordance with the insurer's rates and supplementary rating information filed with the Commissioner.

- Defines "material risk factor" as a risk factor that: (1) was incorrectly recorded or not disclosed by the insured in an application for insurance; (2) was in existence on the date

of the application; and (3) modified the premium charged on the binder or policy in accordance with the rates and supplementary rating information filed by the insurer under Title 11, Subtitle 3 of the Insurance Article.

- Provides that "material risk factor" does not include information that constitutes a material misrepresentation or a change initiated by an insured, including any request by the insured that results in a change in coverage, deductible, or other change to a policy.

- Requires an insurer that recalculates a risk based on the discovery of a material risk factor to provide written notice informing the insured of: (1) the amount of the recalculated premium; (2) the reason for the increase or reduction in the premium; and (3) the insured's right to terminate the policy.

- Requires an insurer to provide written notice, at the time of application or when a binder or policy is issued, of its ability to recalculate the premium from the effective date of the policy during the underwriting period.

Effective Date: ***October 1, 2013***

SENATE BILL 745 (Chapter 570) – <u>Injured Workers' Insurance Fund - Conversion to Chesapeake Employers' Insurance Company</u>

- Converts IWIF from an independent State entity into a statutorily created, private, nonprofit, nonstock workers' compensation insurer to be named the Chesapeake Employers' Insurance Company (Company).

- Requires the Company, before October 1, 2013, to take all steps necessary to become a private, nonprofit, nonstock corporation that is subject to – and has the powers, privileges, and immunities granted by – provisions of law applicable to other insurers authorized to write workers' compensation insurance in the State.

- The Company, beginning October 1, 2013, will maintain IWIF's role as the workers' compensation insurer of last resort in the State.

- Requires the Company to continue to set actuarially sound rates in the same manner in which IWIF sets rates, subject to review by the Commissioner.

- Prohibits the Company from being sold, dissolved, or converted into a mutual or stock company and provides that the Company is not, for any purpose, a department, unit, agency, or instrumentality of the State.

- Provides that all debts, claims, obligations, and liabilities of the Company are not the debts, claims, obligations of the State. Further, money of the Company is not part of the general fund, and the State may not budget for or provide general fund appropriations to the Company.

- Prohibits the Company from cancelling or refusing to renew or issue a policy except for nonpayment of a premium, failure to provide payroll information, or failure to cooperate in a payroll audit.

- Provides that the Company is subject to requirements, currently applicable to IWIF, related to the use of minority business enterprises for specified brokerage and investment management services.

- Requires the Company to submit, to the Governor's Office of Minority Affairs, specified reports that are currently submitted by IWIF.

- Requires IWIF to remain in existence for as long as it continues to have employees; employees of the Company are not employees of the State.

- Prohibits IWIF from hiring new employees on and after October 1, 2013.

- Authorizes employees of IWIF to continue as IWIF employees or elect to be employees of the Company.

- Authorizes employees of IWIF to be assigned to perform functions of the Company under a contract between IWIF and the Company.

- Requires IWIF, before October 1, 2013, to continue to serve as the workers' compensation insurer of last resort for workers' compensation insurance and as a competitive workers' compensation insurer under the same terms and conditions as IWIF serves under current law.

- Prohibits IWIF, on and after October 1, 2013, from issuing new policies or otherwise engaging in the business of insurance, although IWIF may continue to serve as the third-party administrator for the State under a contract with the State.

- Provides that the board for IWIF is the board for the Company.

- Requires the MIA, in consultation with IWIF and the National Council on Compensation Insurance (NCCI), to study whether the Company should be subject to specified ratemaking requirements – including the requirement for NCCI membership – that apply to other workers' compensation insurers. The MIA must report its findings and recommendations to specified committees of the General Assembly by October 1, 2012.

- Requires the MIA to contract with an independent consulting firm to conduct a study to determine the fair value of any financial contribution made by the State to IWIF and any financial benefit received by IWIF from the State. In conducting the study, the firm must consult with IWIF, the Commissioner, and the Secretary of Budget and Management.

- Requires the study to consider the fair value of funds including start-up funds provided by the State to IWIF at any time, IWIF real estate or other assets, and property, transfer, sales, excise, and premium taxes not paid by IWIF. IWIF is responsible for the cost of the study and the MIA is required to report the firm's findings and conclusions to IWIF, the Governor, and specified committees of the General Assembly by October 1, 2012.

- Provides that if the study concludes that the fair value of IWIF is $50 million or more, (1) the MIA must contract with consultants to conduct a comprehensive assessment of the long-term effect of transferring the fair value to the State on the adequacy of IWIF's surplus; and (2) the Company shall owe a debt to the general fund in an amount equal to the fair value less $50 million (the amount to be transferred from IWIF to the general fund under the Budget Reconciliation and Financing Act (BRFA) of 2012), less the cost of the study and the assessment.

- Requires the company, depending on the adequacy of its surplus, to pay the debt in installments beginning in fiscal 2014 or over an alternative period of time as agreed by IWIF and the Secretary of Budget and Management.

- Provides that an installment shall be suspended or delayed in any year in which the Company's risk-based capital ratio is less than 700% of its authorized control level. If this ratio is over the threshold, the MIA may still suspend or delay an installment based on the adequacy of company's surplus or the company's ability to meet its financial obligations.

- Provides that IWIF is responsible for paying the costs of retirement and retiree health benefits.

Effective Date: ***May 22, 2012***

SENATE BILL 1006 (Chapter 336) - Maryland Automobile Insurance Fund - Fund Producers - Commissions

- Authorizes MAIF to determine the rate of commission it must pay to a fund producer of a policyholder to whom a policy is issued.

- Requires the commission rate for private passenger auto insurance to be between 10% and 15% of the total premium, instead of at a rate of 10%.

- Requires MAIF to report by October 1, 2014, to specified legislative committees on MAIF's implementation of a commission payment structure that provides commissions between 10 and 15% to fund producers including whether and how the commission payment structure has: (1) incentivized fund producers to use advanced electronic technology; (2) incentivized fund producers to devote resources to retain policyholders; (3) resulted in administrative cost savings for MAIF; and (4) resulted in fewer uninsured motorists.

Effective Date: ***July 1, 2012***

OTHER

HOUSE BILL 301 (Chapter 120) – Insurance Fraud - Applications for Insurance and Claim Forms - Required Disclosure Statement

- Makes consistent the fraud disclosure statement required to be included on all claim and application forms for insurance with the description of a fraudulent insurance act under § 27-406 of the Insurance Article.

Effective Date: ***January 1, 2013***

HOUSE BILL 1094 (Chapter 589) / SENATE BILL 811 (Chapter 588) – Insurance - Fraud Violations - Fines and Administrative Penalties

- Requires the Fraud Division of the MIA to investigate allegations of civil fraud.

- On a showing by clear and convincing evidence that a fraudulent insurance act has occurred, authorizes the Commissioner to impose an administrative penalty of up to $25,000 for each act of insurance fraud and order restitution to an insurer or self-insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

- Authorizes the Commissioner to bring a civil action in a court of competent jurisdiction to collect an administrative penalty if the penalty is not paid and after all rights of appeal have been waived or exhausted.

- Preserves an insurer's right to take any independent action to seek recovery against a person that commits a fraudulent insurance act.

Effective Date: ***October 1, 2012***

HOUSE BILL 1097 (Chapter 591) / SENATE BILL 812 (Chapter 590) – Insurance - Suspected Fraud - Liability for Reporting or for Furnishing or Receiving Information

- Provides that a person is not subject to civil liability for a cause of action by virtue of reporting suspected insurance fraud, or furnishing or receiving information relating to suspected, anticipated, or completed fraudulent insurance acts, if: (1) the report was made or the information was furnished to or received from specified persons or entities; and (2) the person or entity acted in good faith when making the report or furnishing or receiving the information.

Effective Date: ***October 1, 2012***

HOUSE BILL 435 (Chapter 77) / SENATE BILL 487 (Chapter 76) – Vehicle Laws - Salvage - Defective, Lost, or Destroyed Certificates of Title

- Authorizes an insurance company or its authorized agent that applies for a salvage certificate to submit an affidavit of ownership of the vehicle and a copy of the settlement check or other evidence of final payment instead of a certificate of title, if the certificate of title is defective, lost, or destroyed.

Effective Date: ***October 1, 2012***