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BULLETIN 16- 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 2016 Insurance Legislation Signed into Law By Governor Larry Hogan**

Date: **June 16, 2016**

The purpose of this Bulletin is to summarize laws enacted during the 2016 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 laws, 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 2016 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 2016 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 2016 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 2016 insurance legislation, please contact Nancy Egan at (410) 468-2488 or nancy.egan@maryland.gov.

2016 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 11/SENATE BILL 1 (Chapter 326/Chapter325) – Health Insurance – In Vitro Fertilization – Use of Spouse's Sperm – Exception

- Alters the required conditions for health insurance coverage of in vitro fertilization (IVF) by creating an exception to the required use of the spouse's sperm for heterosexual couples.
- For a patient whose spouse is of the opposite sex the bill requires that the patient's eggs be fertilized with the spouse's sperm, unless: (1) the spouse is unable to produce and deliver sperm; and (2) the inability does not result from a vasectomy or other method of voluntary sterilization.

Effective Date: *July 1, 2016*

HOUSE BILL 124/SENATE BILL 212 (Chapter 55/Chapter 54) – Health Insurance – Large Employers – Disclosure of Aggregate Incurred Claims

- Requires a health insurance carrier that is "experience rating" a large employer's health benefit plan to disclose the "aggregate insured claims" of the group to the large employer within 30 days of a request from a large employer.
- Requires disclosure of aggregate incurred claims to be provided in a format that complies with privacy requirements under the federal Health Insurance Portability and Accessibility Act.

Effective Date: *June 1, 2016*

HOUSE BILL 554/SENATE BILL 436 (Chapter 208/Chapter 207) – Insurance – Surplus Lines – Short-Term Medical Insurance

- Authorizes short-term medical insurance to be purchased from a non-admitted insurer that is eligible to accept the insurance through a qualified surplus lines broker in the State as a surplus line if: (1) the insurance coverage being sought is in excess of coverage available from, or is unavailable from, an admitted insurer in the State that writes that particular kind and class of insurance, and (2) the coverage is provided for a limited time and involves travel to or from the U.S. within 30 days after the effective date of coverage.
- Establishes requirements for pre-existing condition exclusions and sickness definitions under the short-term medical insurance sold on the surplus lines market.
- Requires the surplus lines broker to have an affidavit stating the reason for the declination, for each declining authorized insurer.
- Requires a certain written notice be provided to the applicant by the non-admitted insurer.
- Prohibits non-admitted insurers from selling short-term medical insurance on the surplus lines market to residents of other countries travelling to the U.S. for purpose of attending an institute of higher education.
- Establishes requirements for licensed health insurance brokers who place short-term medical insurance on the surplus lines market.

- Requires the Commissioner to develop and make available on the MIA's website a consumer guide on short-term medical insurance.

Effective Date: *October 1, 2016*

HOUSE BILL 639 (Chapter 109) – Health Insurance – Provider Claims – Payment by Credit Card or Electronic Funds Transfer Payment Method

- Authorizes an insurer, non-profit health service plan, or health maintenance organization ("carrier") to pay a clean claim for reimbursement or an undisputed portion of a claim using a "credit card" or an electronic funds transfer payment method that imposes a fee or charge on the provider if: (1) the carrier notifies the provider in advance of the payment that a fee or similar charge associated with the use of the credit card or electronic funds transfer payment method will apply; and the provider will need to consult the provider's merchant processor or financial institution for the specific rates; (2) the insurer, non-profit health service plan, or health maintenance organization offers the provider an alternative payment method that does not impose a fee or similar charge on the provider; and (3) the provider or the provider's designee elects to accept payment of the claim or a portion of the claim using the credit card or electronic funds transfer payment method.
- Defines "credit card" to mean a credit, debit, pre-paid or stored-value card used to make a payment through a private card network and includes a method of payment to a provider where no physical card is presented.

Effective Date: *October 1, 2016*

HOUSE BILL 798 (Chapter 121) – Health Insurance – Reporting Requirements – Repeal

- Repeals an annual reporting requirement for carriers and dental plan organizations of a summary description of the clinical issues and diagnostic and therapeutic services that were evaluated during the prior year and the conclusion of the evaluation.
- Repeals a duplicative annual reporting requirement for carriers regarding premium rates for health benefit plans.
- Repeals the reporting requirements from private review agents regarding updates to medical criteria used by the private review agents to conduct utilization review.

Effective Date: *June 1, 2016*

HOUSE BILL 801 (Chapter 122) – Health Insurance – Required Conformity with Federal Law

- Amends § 15-137.1(b) of the Insurance Article to correct a cross reference from 45 CFR 146.145(b) to 45 CFR 146.145.
- Repeals § 15-508 of the Insurance Article, which contained permissible uses of pre-existing condition exclusions in the group market which now are prohibited under federal law.
- Amends § 15-508.1 of the Insurance Article, which applies only to grandfathered health benefit plans, to comply with federal law regarding pre-existing condition exclusions in grandfathered health benefit plans.

- Amends the definition of "member" in § 15-10D-01(k) of the Insurance Article to include an applicant who is determined not to be eligible for a health benefit plan. This amendment makes the definition consistent with the coverage decision definition in the same Section and with federal law,
- Amends § 15-1206(c) of the Insurance Article, which deals with minimum participation requirements for a small employer health benefit plan, to change a reference under subsection (c)(3)(i) from the obsolete term of "Standard Plan" to "Bronze Plan."
- Amends § 15-1208.1 of the Insurance Article to make certain corrections to the special enrollment periods for the small group market to be consistent with federal law.
- Amends § 15-1208.2 of the Insurance Article to add an additional special enrollment period when a person decides not to renew his or her coverage under a non-calendar year plan.
- Amends § 15-1315 of the Insurance Article to clarify that the 3 month grace period for individuals receiving advance payment of tax credits also applies at the annual renewal of the health benefit plan.
- Amends § 15-1318 of the Insurance Article to be consistent with the federal requirements for student health plans.

Effective Date: ***June 1, 2016***

HOUSE BILL 803 (Chapter 123) – Life Insurance – Freedom to Travel Act

- Prohibits an insurer from refusing to insure, refusing to continue to insure, limiting the amount or extent or kind of coverage available to an individual, or charging a different rate for life insurance coverage solely for reasons associated with an applicant's or insured's future lawful travel.
- Establishes a specified exception to the above prohibition related to bona fide differences in risk or exposure.
- Requires an insurer to maintain specified data and documents that support the insurer's determination that bona fide differences in risk or exposure exist and to make the data and documents available on request from the Maryland Insurance Commissioner.

Effective Date: ***October 1, 2016***

HOUSE BILL 990 (Chapter 729) – Civil Actions – Liability of Disability Insurer – Failure to Act in Good Faith

- Authorizes the recovery of actual damages, expenses, litigation costs, and interest in first-party claims against insurers if the insurer failed to act in good faith under certain circumstances for first-party claims made under individual disability insurance policies.
- Amends the corresponding reporting requirement by MIA to include in its annual report the number and types of complaints to the MIA from insureds regarding first-party claims under individual disability insurance policies and specified administrative and judicial dispositions of these complaints or actions.

Effective Date: ***October 1, 2016***

HOUSE BILL 1005/SENATE BILL 848 (Chapter 437/Chapter 436) – Health Insurance – Contraceptive Equity Act

- Prohibits carriers (insurers, non-profit health service plans, and health maintenance organizations) from applying a co-payment, coinsurance, or prior authorization requirement under a non-grandfathered health benefit plan for specified contraceptive drugs and devices that are approved by the U.S. Food and Drug Administration and obtained under a prescription written by an authorized prescriber. An exception from the zero co-payment/coinsurance requirement is provided if the contraceptive drug or device is therapeutically equivalent to another contraceptive drug or device that is available under the same policy or contract without a co-payment or coinsurance requirement.
- Adds a requirement for a 6 month supply of contraceptives for all health benefit plans covering contraceptive drugs. An exception is provided for: (1) the first two month supply of an initial prescription for the contraceptive; and (2) if the 6 month supply would extend beyond the plan year.
- Requires coverage without a prescription of over the counter contraceptive drugs approved by the U.S. Food and Drug Administration and available by prescription and over the counter for all contracts covering contraceptives, if the over the counter contraceptive drugs are purchased from in-network pharmacies.
- Requires coverage of male sterilization under group contracts that are not small employer contracts. An exception is provided for contracts of certain religious organizations.
- If an individual, group or blanket health insurance policy or contract of an insurer or non-profit health service plan or an individual or group health maintenance organization contract covers male sterilization, prohibits the carrier from applying a co-payment, coinsurance requirement or deductible to coverage for male sterilization.
- Requires the carrier to permit an individual to receive a contraceptive drug or device that is not on the carrier's formulary, if in the judgment of the authorized prescriber the contraceptive drug or device is medically necessary for the individual to adhere to the appropriate use of the prescription drug or device.
- Prohibits the Maryland Medical Assistance Program and the Maryland Children's Health Program from applying a prior authorization requirement for certain contraceptive drugs.
- Requires the Maryland Medical Assistance Program and the Maryland Children's Health Program to provide coverage for a single dispensing to an enrollee of a 6 month supply of prescription contraceptives. An exception is provided for the first 2-month supply of prescription contraceptives issued as the initial prescription for the contraceptive or any subsequent prescription for a contraceptive that is different than the last contraceptive dispensed to the individual.

Effective Date: ***January 1, 2018***

HOUSE BILL 1247 (Chapter 305) – Insurance – Self-Funded Student Health Plans

- Exempts from specified State insurance laws a self-funded student health plan operated by certain independent institutions of higher education that provide health care services to its students and their dependents if the institutions file a specified report with the Commissioner by July 1 each year, for the student health plan that will be offered to students for the upcoming school year and otherwise complies with the provisions of § 1-202(a)(5) of the Insurance Article. Self-funded student health plans operated by an

independent institution of higher education are subject to Title 15 Subtitle 10A and 10D of the Insurance Article.

- Permits institutions of higher education to offer self-funded student health plans if they satisfy the following requirements prior to offering the student health plan: (1) the student health plan satisfies any applicable minimum essential coverage standards under federal law; (2) the institution pledges assets sufficient to support the liabilities of the student health plan; (3) the institution demonstrates an ability to operate the student health plan in a sound manner by having operated an employer–sponsored plan, as defined in § 15-1401 of the Insurance Article, in the prior calendar year with at least 10,000 enrollees, including employees and their dependents; (4) the institution maintains at least an AA bond rating by one of the major credit rating agencies; and (5) the self-funded student health plan has internal appeals and grievance procedures and complaint processes for coverage decisions that are operated in compliance with Title 15, Subtitles 10A and 10D of the Insurance Article.

Effective Date: ***April 26, 2016***

HOUSE BILL 1318 (Chapter 309) – <u>Health Benefit Plans – Network Access Standards and Provider Network Directories</u>

- Requires the Commissioner, in consultation with interested stakeholders, to adopt regulations to establish quantitative and, if appropriate, non-quantitative criteria to evaluate the network sufficiency of health benefit plans on or before December 31, 2017.
- Requires regulations adopted by the Commissioner to identify the parts of the access plan that may be considered confidential by the carrier.
- Requires insurers, non-profit health service plans, and health maintenance organizations to file with the Commissioner, on or before July 1, 2018 and then annually thereafter an access plan regarding network adequacy.
- Requires insurers, nonprofit health service plans, and health maintenance organizations that make material changes to the access plan to notify the Commissioner of the change within 15 business days after the change occurs.
- Requires the Commissioner, in consultation with appropriate stakeholders, to adopt regulations, on or before December 31, 2017, that specify network adequacy standards for dental services for an entity that is a dental plan organization, an insurer, or a non-profit health service plan .
- Establishes the information that is required to appear in each carrier's network directory.
- Requires an insurer, non-profit health service plan, health maintenance organization, and dental plan organization to update its network directory information provided on the internet at least once every 15 days. Printed copies of network directories are required to be updated at least once a year.
- If an insurer, non-profit health service plan, health maintenance organization, or dental plan organization is notified of a potential inaccuracy in a network directory by a person other than the provider, requires the network directory to be updated within 45 working days after receipt of the notification.
- Requires a carrier (insurer, non-profit health service plan, health maintenance organization, and dental plan organization) to: (1) periodically review a sample of their network directory for accuracy and retain documentation of the review; or (2) contact

providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the provider intends to remain in the carrier's provider network.

- Requires a carrier (insurer, non-profit health service plan, health maintenance organization, and dental plan organization) to accept new and updated network directory information for a provider submitted: (1) through the multi-carrier common online provider directory information system designated by the Commissioner; or (2) directly to the carrier.
- Requires procedures established by carriers (insurer, non-profit health service plan, health maintenance organization, and dental plan organization) to ensure that a request to obtain a referral to a specialist or non-physician specialist who is not part of the carrier's provider panel is addressed in a timely manner. Includes a requirement that carriers document all requests to obtain a referral to receive a covered service from a specialist or non-physician specialist who is not part of the carrier's provider panel and to provide the documented information to the Commissioner upon request.
- Transfers oversight of network adequacy for health maintenance organizations from DHMH to the MIA effective January 1, 2018.
- Requires that any certification standards established by the Exchange related to network adequacy or network directory accuracy may not be implemented until January 1, 2019 and shall be consistent with those requirements under Section 15-112 of the Insurance Article.

Effective Date: ***Various***

SENATE BILL 297 (Chapter 371) – <u>Health Insurance – Habilitative Service – Period of Time for Coverage</u>

- Revises the current definitions in the mandated health insurance benefit for habilitative services to be consistent with the definitions found in federal regulations adopted under the Patient Protection and Affordable Care Act.
- Clarifies that the habilitative service benefits continue for children until at least the end of the month in which the child turns 19 years old.

Effective Date: ***October 1, 2016***

SENATE BILL 887 (Chapter 445) – <u>Health Insurance – Consumer Health Claim Filing Fairness Act</u>

- Requires carriers (insurers, non-profit health service plans, and health maintenance organizations) to include provisions in each health benefit plan contract that permits enrollees a minimum of 1 year to submit a claim for a service.
- Requires carriers to suspend the minimum 1 year period of time to file the claim while the enrollee is legally incapacitated
  Provides that failure to submit a claim within the minimum period of time does not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit

the claim within 1 year after the date of service and the claim is submitted within 2 years after the date of service.

Effective Date: *January 1, 2017*

PROPERTY AND CASUALTY

HOUSE BILL 3/SENATE BILL 54 (Chapter 28/Chapter 16) – Public Utilities – Transportation Network Services and For Hire Transportation – Clarifications

- Clarifies that the Maryland Auto Insurance Fund ("MAIF") 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.
- Clarifies and conforms provisions of law pertaining to transportation network services and other types of for hire transportation including provisions regarding criminal records checks, assessments and enforcement.

Effective Date: *April 8, 2016*

HOUSE BILL 501 (Chapter 488) – Motor Vehicle Insurance – Volunteer Drivers

- Prohibits motor vehicle liability insurers from: (1) canceling or refusing to issue an insurance policy to an insured or applicant solely because he or she is a volunteer driver; or (2) imposing a surcharge or increasing the rates on a policy because the insured or applicant, a member of the insured's or applicant's family, or someone who normally operates the insured's or applicant's motor vehicle is a volunteer driver.
- Defines "volunteer driver" as an individual who provides driving services, including the transportation of people or goods, to a legally recognized charitable or not-for-profit organization in the State without compensation other than for expenses.
- Applies to a policy of motor vehicle liability insurance issued, sold, delivered, or renewed in the State on or after January 1, 2017.

Effective Date: *October 1, 2016*

HOUSE BILL 557 (Chapter 491) – Homeowner's Insurance – Underwriting Standards – Deductibles

- Authorizes an insurer to issue a policy of homeowner's insurance that includes a deductible that is equal to a percentage of the "Coverage A-Dwelling" limit of the policy.
- Authorizes the insurer to require a percentage-based deductible in a policy of homeowner's insurance or to offer a percentage-based deductible as an option.
- Requires that an insurer that has issued a homeowner's policy that includes a mandatory percentage-based hurricane deductible to only apply the deductible beginning at the time the National Hurricane Center has issued a hurricane warning for any part of the state and ending 24 hours following the termination of the last hurricane warning issued for any part of the state regardless of where the insured's home is located in the State.

- Repeals the requirement that an insurer that issues a policy of homeowner's insurance file with the Commissioner for approval an underwriting standard that requires a percentage deductible for hurricanes that exceeds 5% before the insurer may implement the underwriting standard. The insurer still must file the underwriting standard for information with the Commissioner.
- Requires an insurer that issues a homeowner's policy that includes a percentage-based deductible to provide a policyholder with an annual statement with certain requirements explaining the manner in which the deductible is applied. An insurer may as an alternate to the statement include certain information on the declarations page explaining how the deductible applies.
- Requires an insurer to send a copy of a form used to provide the statement to the Commissioner for information prior to its use.

Effective Date: *January 1, 2017*

HOUSE BILL 631 (Chapter 493) – Workers' Compensation – Permanent Partial Disability – Howard County Deputy Sheriffs Ho. Co. 11-16

- Alters the circumstances under which Howard County deputy sheriffs are eligible for enhanced workers' compensation benefits for permanent partial disability claims by eliminating certain requirements to qualify.

Effective Date: *October 1, 2016*

HOUSE BILL 675 (Chapter 494) – Vehicle Laws – Mechanical Repair Contracts

- Alters the definition of "mechanical repair contact" to include any agreement or contract sold by an "agent" of a licensed vehicle dealer or an obligor. Authorizes an agent of a registered obligor under a mechanical repair contract to offer, sell, or negotiate a mechanical repair contract.
- Establishes that an obligor or a vehicle dealer is liable for the actions of its agent when the agent is offering or selling a mechanical repair contract on behalf of the obligor or vehicle dealer.
- Establishes a civil penalty for an agent or an agent's employee that violates provisions of the Act.
- Requires an obligor or a licensed vehicle dealer that uses an agent to sell a mechanical repair contract to maintain a list and, on request, make the list available to the Insurance Commissioner. Additionally, the agent is required to maintain a list of each employee authorized to sell mechanical repair contracts and, on request, make the list available to the agent's obligor or licensed vehicle dealer within 10 days of the request.
- Increases the penalty for a violation of provisions of the Mechanical Repair Contract statute.

Effective Date: *October 1, 2016*

HOUSE BILL 720/SENATE BILL 544 (Chapter 402/Chapter 401) – Motor Vehicle Insurance – Insurance Identification Card – Carrying Proof of Coverage – Uninsured Motorist Education and Enforcement Fund

- Requires the driver of a motor vehicle to carry evidence of required security (normally proof of insurance) while operating the vehicle.
- A person who violates this requirement is subject to a fine of $50.00 which may be waived but, if collected, must be deposited into the Uninsured Motorist Education and Enforcement Fund ("UMEEF"). UMEEF is administered by the Motor Vehicle Administration and its revenues must be used to administer the fund and educate drivers about and enforce the security requirements for motor vehicles under Maryland law.
- Requires an insurer to provide to an insured an insurance identification card or to provide the information in an electronic format upon consent of the insured. The form must be prescribed or approved by the Commissioner.
- The insurance identification card shall indicate: (1) the first named insured on the policy; (2) the vehicles covered under the policy; and (3) the period for which coverage is in effect.

Effective Date: ***October 1, 2016***

HOUSE BILL 900/ SENATE BILL 784 (Chapter 426/Chapter 425) – Motor Vehicle Insurance Personal Injury Protection – Rejection of Coverage

- Exempts an applicant for a motor vehicle liability insurance policy from being required to obtain coverage for medical, hospital, and disability benefits known as personal injury protection ("PIP") benefits that must otherwise be provided (full PIP) or waived (limited PIP) if certain conditions are met.
- Authorizes an applicant to reject PIP while applying for motor vehicle insurance policy if the coverage being obtained is not in excess of the minimum liability coverage required by State law.
- Requires MAIF to offer the option to reject PIP coverage to an eligible applicant while other insurers may offer to do so. MAIF must offer the option to reject PIP to an applicant but only if they have not been continuously insured by MAIF for 1 year prior to the time of application.
- Insurers may offer an eligible applicant the ability to reject PIP, but only if the application is for coverage not exceeding the minimum required liability coverage, the applicant's prior insurance was not with MAIF and the prior policy was cancelled by the insurer before the end of the policy term.
- Requires an insurer (including MAIF), at the time of renewal, to upgrade such a policy to provide limited PIP coverage, unless the insured chooses to upgrade to full PIP coverage.
- Requires the Commissioner to consult with insurers, insurance producers, and any other person that the Commissioner determines is appropriate in developing the form required including use of the form by written and electronic means.
- Requires MAIF and other insurers that offer the option to reject coverage, to report specified information to the MIA each year through 2019; and the MIA must compile the information and submit its findings and recommendations to specified committees of the General Assembly by December 1, 2019.

Effective Date: ***October 1, 2016***

HOUSE BILL 912/SENATE BILL 888 (Chapter 447/Chapter 446) – Motor Vehicle Insurance – Program to Incentivize and Enable Uninsured Vehicle Owners to be Insured

- Establishes the Program to Incentivize and Enable Uninsured Vehicle Owners to Be Insured ("Program") to be administered by the MVA.
- Requires the MVA to: (1) waive 80% of a vehicle owner's delinquent uninsured vehicle penalties that became delinquent before January 1, 2014; and (2) require those vehicle owners to purchase and maintain the required security for their vehicles as a condition of this waiver of penalties.
- Requires the MVA to notify vehicle owners who may be eligible. The notification must meet certain requirements.
- Establishes that the Program period during which MVA may waive a vehicle owner's delinquent uninsured vehicle penalties must last up to 90 calendar days and begin on or after January 1, 2017, and end by December 31, 2017.
- Establishes that a vehicle owner may participate if he or she is (1) a resident of the State; (2) has delinquent uninsured vehicle penalties that became delinquent before January 1, 2014; (3) does not have the required security on a vehicle; and (4) has not been issued a judgment by the Department of Budget and Management ("DBM") collection unit.
- Provides that a program participant must pay the remaining 20% owed before the end of the period and if applicable any fee owed payable to DBM collection unit calculated using the 20% owed.
- Permits a participant to pay these penalties in a monthly installment, subject to certain conditions.
- Requires the MVA to coordinate with the MIA to publicize the program including notifying insurers and producers.
- Requires the MVA within 60 days after the end of the program period to report to the Governor and General Assembly on the results of the program and any recommendations to implement another program aimed at reducing the number of uninsured motorists.

Effective Date: ***July 1, 2016***

HOUSE BILL 958 (Chapter 499) – Insurance – Rate Filing – Trade Secrets

- Specifies that the proprietary rate-related information of an insurer subject to Title 11, subtitle 3 of the Insurance Article that is filed with the Commissioner: (1) constitutes a trade secret and confidential commercial information; (2) must be kept confidential by the Commissioner subject to certain exceptions; and (3) is not subject to subpoena served on the Commissioner or any recipient of proprietary rate-related information authorized by the chapter law. An insurer may not designate the rating factors used to calculate the premium as proprietary rate-related information.
- Authorizes the Commissioner to disclose the information for certain purposes or to certain persons including the People's Insurance Counsel Division who must maintain the confidentiality of the proprietary rate-related information.
- Requires the Commissioner, if the Commissioner makes a determination that the filed information is not proprietary rate related information, to notify the insurer 10 business

days after making the determination. After the 10 day period, the Commissioner shall make the material open for public inspection.

- Permits an insurer within the 10 day period to withdraw the filing if the insurer has not put the rate filing in effect and has notified the Commissioner of the withdrawal. If the insurer meets these conditions, the Commissioner may not disclose the information to the public.

Effective Date: ***October 1, 2016***

HOUSE BILL 1408 (Chapter 137) – Property and Casualty Insurance – Commercial Policies and Workers' Compensation Insurance Policies – Notices of Premium Increases

- Alters the scope of provisions of law that require an insurer to send to persons a notice of premium increase for policies of commercial insurance and policies of workers' compensation insurance.
- Provides that the provisions of law do not apply to policies for which the renewal policy premium is an increase of 15 percent or less over the expiring policy premium.
- Clarifies that an insurer may not be required to comply with the notice requirement if a separate notice containing specified information is sent. The bill permits the notice requirement to have been met when an insurer sends this separate notice.

Effective Date: ***October 1, 2016***

HOUSE BILL 1487/SENATE BILL 450 (Chapter 210/Chapter 209) – Health Care Provider Malpractice Insurance – Scope of Coverage

- Authorizes a medical malpractice insurance insurer to include coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider's profession if the cost of the included coverage is: (1) itemized in the billing statement, invoice, or declarations for the policy; and (2) reported to the Insurance Commissioner.

Effective Date: ***October 1, 2016***

SENATE BILL 505 (Chapter 394) – Workers' Compensation Insurance – Premium Discount – Alcohol – and Drug-Free Workplace Program

- Authorizes a workers' compensation insurer to file a rating plan with the Commissioner that provides for a premium discount up to 4% for an insured employer if the employer has an alcohol-and drug-free workplace policy that includes one of six specified programs.
- Provides that an insurer is not required to provide a premium discount if the insured employer is required by federal or State law to test its employees for drugs or otherwise maintain an alcohol- and drug-free workplace.

Effective Date: ***October 1, 2016***

SENATE BILL 541 (Chapter 73) – Portable Electronics Insurance – Required Notices – Method of Mailing

- Alters the method of mailing from first-class mail tracking method to regular mail that an insurer or vendor is require to use when the insurer or vendor sends to a policy holder or covered customer notices about a termination or any other change in the terms and conditions of a policy of portable electronics insurance.

Effective Date: *October 1, 2016*

SENATE BILL 750 (Chapter 693) and House Bill 919 (Chapter 694) – Portable Electronics Insurance – Compensation of Vendor Employees – Repeal of Sunset and Reporting Requirement

- Repeals the sunset provision relating to § 10-703(e), which authorizes the employees of a vendor or authorized representative of a vendor of portable electronics insurance to be compensated in part based on the sale of portable electronics insurance.
- Repeals a requirement that the Maryland Insurance Administration issue a report to committees of the General Assembly relating to the sales practices of vendor employees.

Effective Date: *July 1, 2016*

OTHER

HOUSE BILL 60 (Chapter 84) – Insurance – Certificate of Qualification, Licensing, and Registration – Electronic Means

- Alters the renewal date for certificates of qualification for both surplus lines brokers and insurance advisors from June 30 to every other year on the date stated on the certificate. For an individual, a license renewal shall have an expiration date that is the last day of the month in which the holder of the certificate was born.
- Authorizes the Commissioner to send renewal notices to the electronic mail address of the holder of record relating to the renewal of the certificate of qualification of a surplus lines broker, the license of an insurance producer, insurance adviser, or motor club and the registration of a motor club representative
- Establishes when renewal applications submitted electronically are considered made in a timely manner.
- Adds a requirement for life and health producers and property and casualty producers to file with the Commissioner a change in the licensee's electronic mail address within 30 days of the change.

Effective Date: *January 1, 2017*

SENATE BILL 75 (Chapter 155) – Insurance – Public Adjusters – Licensing

- Repeals the employment requirements for public adjusters qualifying for a license to have been employed regularly by the Insurance Administration as an employee or by an insurer, adjuster, insurance producer or public adjuster for a period totaling at least 1 year.
- Authorizes the Insurance Commissioner to send license renewal notices by electronic mail to the electronic mail address of the holder of record 1 month before license expires.
- Alters the renewal date for public adjuster licenses from June 30 to every other year on the date stated on the certificate. For an individual, a license renewal shall have an expiration date that is the last day of the month in which the holder of the certificate was born.
- Requires a public adjuster to successfully complete 24 credit hours of approved continuing education of which 3 hours shall be directly related to ethics for each 2-year license period as a condition for license renewal unless the Commissioner modifies the requirement by regulation.
- Provides for the satisfaction of continuing education requirements by non-resident license holders if the non-resident license holder satisfies the continuing education requirements of the home state of the non-resident licenses holder and the home state of the non-resident license holder allows a public adjuster who is a resident of this State to satisfy the continuing education requirements of the home state on the same basis by meeting the continuing education requirements of this State.
- Authorizes for up to 1 year after the expiration date, a person whose public adjuster's license has expired to reinstate the expired license by filing with the Commissioner the appropriate reinstatement application, paying to the Commissioner the applicable reinstatement fee, and submitting proof of completion of the continuing education requirements.

Effective Date ***January 1, 2017***

SENATE BILL 240 (Chapter 56) – Maryland Insurance Commissioner – Responsibility for Holding Hearings – Delegation

- Authorizes the Commissioner to delegate the responsibility for holding a hearing to one additional Insurance Administration employee who is designated by the Commissioner and admitted to the practice of law in the State.

Effective Date ***July 1, 2016***