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SUMMARY OF 2001 INSURANCE LEGISLATION
SIGNED INTO LAW BY GOVERNOR PARRIS N. GLENDENING

This bulletin is meant to place insurers authorized to write insurance in Maryland on notice of the insurance laws (Insurance Article §1-101 et seq., Annotated Code of Maryland) passed by the 2001 Maryland General Assembly. *The attached synopsis is intended to serve only as a guide.* All insurers should refer to the 2001 Chapter Laws of Maryland for complete drafts of the law. Insurers are advised that other bills passed by the General Assembly and not listed on the synopsis may also affect their business operations in Maryland.

For a copy of a specific law passed by the General Assembly during the 2001 legislative session, you may contact the Department of Legislative Services at (410) 946-5400 or, on the internet, at <http://mlis.state.md.us>. In addition, you may also obtain a copy of the 2001 Session Review from Library and Information Services, Office of Policy Analysis, Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401-1991 or call (410) 946-5400.

For additional information concerning the Maryland Insurance Administration's Summary of Legislation, please contact Kathleen Loughran, Director of Government Affairs, at (410) 468-2014.

2001 INSURANCE LEGISLATION

AGENT LICENSING

SENATE BILL 576 (Chapter 731) - Insurance Producer Licensing Act

Among other things, SB 576 accomplishes:

- Reciprocity
 - deletes the bond requirement for non-residents;
 - deletes the requirement that a non-resident agent have an appointment within the two years preceding renewal;
 - allows limited lines licensees from other states to receive a similar limited lines license in this State;
 - allows surplus lines brokers to be licensed as non-resident;
 - amends the statute to provide that all producers licensed in good standing in their home state will receive a non-resident license in this State upon application and upon payment of the application fee, without further documentation or other requirements; and
- Uniformity
 - generally adopts the NAIC Model law;
 - eliminates separate licenses for brokers and agents ("Producers");
 - deletes the bond requirement for both residents and non-residents;
 - eliminates the separate license for fraternal agents;
 - adopts uniform standards for termination of appointments;
 - expands the definition of business entity to include professional associations and limited liability partnerships; and
 - allows for reciprocity in C.E. course/provider approval.

Effective date: July 2, 2001

LIFE AND HEALTH

SENATE BILL 132 (Chapter 26) - Health Insurance - Standard Provisions

This bill strikes two standard contract provisions from the law:

- § 15-227 of the Insurance Article, which is the standard contract provision for noncoverage of a loss resulting from the insured's involvement in an illegal occupation.
- § 15-228 of the Insurance Article, which is the standard contract provision for noncoverage of a loss sustained or contracted as a result of the insured's being intoxicated or under the influence of any narcotic unless administered by a physician.

Effective date: January 1, 2002

SENATE BILL 457 (Chapter 388) - Health Insurance - Study of Maryland's Small Group Market

- Requires the Maryland Health Care Commission to:
 - (1) contract with an independent consultant to conduct a study comparing the performance of Maryland's small group health insurance market reform law to other states; and
 - (2) instruct the independent consultant to meet with and to provide periodic updates to an independent advisory committee comprised of small employers participating in the small group market, small employers who do not purchase group health insurance, insurers providing coverage in Maryland in the small group market, insurers not participating in the small group market in Maryland, HMOs, and agents and brokers in the small group market.
- In addition, SB 457 requires the study to include certain analysis and recommendations.
- Requires the Maryland Health Care Commission to report the findings and recommendations of the study to the Governor and the General Assembly on or before January 1, 2002.

Effective date: June 1, 2001. (This law shall be abrogated and of no further force and effect on January 1, 2002.)

SENATE BILL 458 (Chapter 389) - Health Insurance - Substantial, Available, and Affordable Coverage

- Defines health benefit plan under § 15-606.1(3) of the Insurance Article to specifically include certain coverages, as well as, exclude certain coverages and benefits.
- Defines SAAC under § 15-606.1(A)(4) of the Insurance Article to mean coverage that is offered in the nongroup health insurance market under the regulations adopted under § 15-606 of the Insurance Article.
- Applies to each carrier that offers a medically underwritten health benefit plan in the nongroup market in Maryland.
- Defines carrier to mean an insurer, nonprofit health benefit plan, or HMO.
- Requires a carrier that denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market to provide the individual with specific information regarding the availability of SAAC coverage in the form and manner required by the Commissioner (§ 15-606.1(C)(1) of the Insurance Article).
- Requires the Commissioner to:
 - (I) adopt regulations to facilitate the implementation of § 15-606.1(C)(1) of the Insurance Article; and
 - (II) develop a mechanism to provide verbally, in writing, or by electronic means, information to individuals, on request, about the availability of SAAC.
- Requires each carrier that offers a SAAC plan in the nongroup market to notify the Commissioner in writing, no later than January 1 of each year, of the time periods in that calendar year during which the carrier will offer its SAAC plan on an open enrollment basis.
- Section 2 of SB 458:
 1. Permits a carrier that offered a SAAC indemnity plan to any subscriber on January 1, 2001 to continue to provide that plan to existing subscribers of the plan;
 2. Provides that the plan is deemed in continued compliance with plan requirements under § 15-606 of the Insurance Article and the regulations adopted by the Health Services Cost Review Commission for SAAC plans; and

3. Provides that this provision of SB 458 shall remain in effect for two years and, at the end of June 30, 2003, shall be abrogated and of no further force and effect.

Effective date: October 1, 2001

SENATE BILL 511 (Chapter 157) - Health Insurance - Requirements for Providers to Serve on Provider Panels - Dental Plans

- Alters the definition of health benefit plan under § 15-112(e)(1) of the Insurance Article to include dental plans and other health benefit plans that contract with dentists to offer dental care services.

Effective date: October 1, 2001

SENATE BILL 522 (Chapter 736) - Health Insurance - Treatment of Morbid Obesity

- Defines "body mass index" and "morbid obesity".
- Applies to the following entities:
 - (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State;
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; and
 - (3) managed care organizations, as defined in § 15-101 of the Health-General Article.
- Requires an entity to provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is:
 - (1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and
 - (2) consistent with criteria approved by the National Institutes of Health.
- Requires an entity to provide the benefits required under this law to the same extent as for other medically necessary surgical procedures under the enrollee's or insured's contract or policy with the entity.

Effective date: October 1, 2001

SENATE BILL 591 (Chapter 406) - Health Insurance - Claims for Reimbursement for Health Care Services Rendered

- Clarifies § 15-1005(d)(1) of the Insurance Article that an insurer, nonprofit health service plan, or HMO must permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.
- Requires an insurer, nonprofit health service plan, or health maintenance organization that wholly or partially denies a claim for reimbursement to permit a provider a minimum of 90 working days after the date of denial of the claim to appeal the denial (§ 15-1005(d)(2) of the Insurance Article).
- Applies to claim denials made on or after October 1, 2001.

Effective date: October 1, 2001

SENATE BILL 686 (Chapter 416) - Health Insurance Benefit Cards, Prescription Benefit Cards, or Other Technology

- Applies to the following entities:
 - (I) insurers and nonprofit health service plans that provide coverage for prescription drugs on an outpatient basis under health insurance policies or contracts that are issued or delivered in the State;
 - (II) health maintenance organizations that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State;
 - (III) managed care organizations, as defined in § 15-101 of the Health-General Article, that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State; and
 - (IV) to the extent consistent with State and federal law, third party administrators.
- Exempts from the provisions of SB 686:
 - (I) short-term travel or accident-only policies;
 - (II) short-term nonrenewable policies of not more than six months' duration; or
 - (III) any health maintenance organization that operates or maintains its own pharmacies and dispenses, on an annual basis, over 90 percent of

prescription drugs on an outpatient basis to its enrollees at its own pharmacies.

- Requires an entity subject to the law to provide to its insureds, subscribers, or enrollees a health insurance benefit card, prescription benefit card, or other technology that:
 - (1) complies with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of issuance of the card or other technology; or
 - (2) includes, at a minimum, the following data elements:
 - (I) The name or identifying trademark of the entity subject to this section or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator;
 - (II) the name and identification number of the insured, subscriber, or enrollee;
 - (III) the telephone number that providers may call for pharmacy benefit assistance; and
 - (IV) all electronic transaction routing information and other numbers required by the entity subject to this section or benefit administrator to process a prescription claim electronically.
- Requires an entity subject to the law that contracts with or otherwise arranges for the prescription benefit to be administered by another subsidiary or entity, including a pharmacy benefit manager, to require the benefit administrator to comply with the law.
- Requires the health insurance benefit card, prescription benefit card, or other technology to be issued to each insured, subscriber, or enrollee by an entity subject to the law.
- Requires an entity subject to the law, when there is a change in any of the data elements, to:
 - (I) reissue a health insurance benefit card, prescription drug benefit card, or other technology; or
 - (II) provide the insured, subscriber, or enrollee with the corrective information necessary to electronically process a prescription claim.

- Allows an entity subject to the law to comply with the law by issuing to each insured, subscriber, or enrollee a health insurance benefit card that contains data elements related to both prescription and nonprescription health insurance benefits.
- Requires DHMH to adopt regulations to enable managed care organizations to comply with:
 - (1) the law; and
 - (2) any unique requirements of the HealthChoice Program that relate to the electronic processing of claims.

Effective date: October 1, 2001

SENATE BILL 728 (Chapter 423) - Health Maintenance Organizations - Reimbursement of Noncontracting Providers for Services Rendered to Trauma Patients at Designated Trauma Centers

- Alters the definition of "covered service" under § 19-710(a)(3) of the Health-General Article to mean a health care service included in the benefit package of the health maintenance organization and rendered to an enrollee of the health maintenance organization by a health care provider, including a physician or hospital, not under written contract with the health maintenance organization.
- Alters the definition of "adjunct claims documentation" to mean an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland ambulance information systems form, or a medical record.
- Defines the following terms:

Under § 19-710.1(5) of the Health-General Article, "Institute" is the Maryland Institute for Emergency Medical Services System.

Under § 19-710.1(6) of the Health-General Article:

 - (l) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the Institute to provide care to trauma patients.

- (II) "Trauma center" includes an out-of-state pediatric facility that has entered into an agreement with the Institute to provide care to trauma patients.

Under § 19-710.1(7) of the Health-General Article, "trauma patient" is a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

Under § 19-710.1(8) of the Health-General Article, "trauma physician" is a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

- Requires an HMO or its agent, for a covered service rendered to an enrollee of the HMO by a health care provider not under written contract with the HMO, to pay the claim submitted by a trauma physician for trauma care rendered to a trauma patient in a trauma center at the greater of:
 - (A) 140 percent of the rate paid by the Medicare Program, as published by HCFA for the same covered service to a similarly licensed provider; or
 - (B) the rate as of January 1, 2001 that the HMO paid in the same geographic area for the same covered service to a similarly licensed provider.
- § 19-710.1(b)(3) permits an HMO to require a trauma physician not under contract with the HMO to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the HMO.
- Requires an HMO that imposes the provisions of § 19.710.1(b)(3) on a trauma physician to assign a provider number to a trauma physician not under contract with the HMO, at the request of the physician.
- SB 728 shall remain effective until the termination provision in Chapter 275, Acts of 2000, takes effect.

Effective date: October 1, 2001

SENATE BILL 856 (Chapter 173) - Health Insurance - Appeals and Grievances Procedures - Modifications

- Requires a carrier under § 15-10A-02(b) of the Insurance Article to allow a member or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision for a retrospective denial.

- Alters § 15-10A-03(a)(1) to allow, within 30 **working** days after the date of receipt of a grievance decision, a member or a health care provider, who filed the grievance on behalf of the member under § 15-10A-02(b)(2) of the Insurance Article, to file a complaint with the Commissioner for review of the grievance decision.
- Requires each carrier subject to § 15-10A-06 of the Insurance Article to file with the Commissioner, on the form the Commissioner requires, a report that describes the number of adverse decisions issued by the carrier under § 15-10A-02(F) of the Insurance Article and the type of service at issue in the adverse decisions.
- Applies § 15-10A-03(a)(1) to all adverse decisions and grievance decisions made on or after October 1, 2001.
- Applies § 15-10A-06(a)(1)(vi) to adverse decisions made on or after January 1, 2002.

Effective date: October 1, 2001

HOUSE BILL 6 (Chapter 135) - Senior Prescription Drug Relief Act

Among other things, HB 6:

- Establishes the Maryland Pharmacy Discount Program under § 15-124.1 of the Health-General Article.
- Requires the Secretary of the Department of Health and Mental Hygiene (DHMH) to administer the Pharmacy Program as part of the Maryland Medical Assistance Program.
- Establishes the Maryland Medbank Program under § 15-124.2 of the Health-General Article.
- Alters the Short-Term Prescription Drug Subsidy Plan established under Title 15, Subtitle 6 of the Health-General Article.

Effective date: July 1, 2001 with certain exceptions. Also, Sections 9, 10, and 16 of the bill take effect on June 1, 2001.

HOUSE BILL 15 (Chapter 178) - Nonprofit Health Entity Accountability

Among other things, HB 15 sets forth the following:

- An exemption from taxation shall be granted to nonprofit health service plans under § 6-101(B)(1) of the Insurance Article so that funds which would

otherwise have been collected by the State and spent for public purpose shall be used in a like manner and amount by the nonprofit health service plan.

- HB 15 does not apply to a nonprofit health service plan that insures less than 10,000 covered lives.
- Requires each nonprofit health service plan subject to the bill to file with the Commissioner a premium tax exemption report that:
 - (1) is in a form approved by the Commissioner, and
 - (2) demonstrates that the plan has used funds equal to the value of the premium tax exemption provided to the plan under § 6-101(B) of the Insurance Article in a manner that serves the public interest in accordance with § 14-106(D) of the Insurance Article.
- Each report filed with the Commissioner is a public record.
- A nonprofit health service plan that fails to timely file the report required under § 14-106 of the Insurance Article shall pay the penalties under § 14-121 of the Insurance Article.
- By November 1 of each year, the Commissioner shall issue an order notifying each plan required to file a report under § 14-106 of the Insurance Article of whether the plan has satisfied the requirements of § 14-106 of the Insurance Article.
- A plan that does not meet the requirements of § 14-106 of the Insurance Article shall have one year from the date the Commissioner issued the Order to comply with the requirements of § 14-106 of the Insurance Article.
- A party aggrieved by an Order of the Commissioner issued under § 14-106 of the Insurance Article has a right to a hearing in accordance with §§ 2-210 through 2-215 of the Insurance Article.
- If after one year from the Order the Commissioner determines that a plan has not satisfied the requirements of § 14-106 of the Insurance Article, the Commissioner shall report the determination to the House Economic Matters Committee and the Senate Finance Committee.
- Only by an Act of the General Assembly can a nonprofit health service plan be subject to the premium tax under Title 6, Subtitle 1 of the Insurance Article.

Effective date: October 1, 2001

HOUSE BILL 25 (Chapter 179) - Life Insurance - Insurable Interest in Adopted Child

- Clarifies that for a prospective parent of a prospective adoptive child, an insurable interest exists in the life of the child as of the date of the earlier of:
 1. A placement for adoption, as defined in § 5-301 of the Family Law Article, provided that:
 - A. any consents required under § 5-311 of the Family Law Article have been given; or
 - B. a decree awarding guardianship has been granted under § 5-317 of the Family Law Article; or
 2. An interlocutory or final degree of adoption.

Effective date: October 1, 2001

HOUSE BILL 160 (Chapter 445) - Health Insurance - Hearing Aids - Coverage for Children

- Applies to:
 - (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- Requires an entity subject to § 15-837 of the Insurance Article to provide coverage for hearing aids for a minor child who is covered under a policy or contract if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.
- An entity subject to § 15-837 of the Insurance Article may limit the benefit payable under § 15-837(c)(1) to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.
- Applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2001.

Effective date: October 1, 2001

HOUSE BILL 179 (Chapter 53) - Health Insurance - Private Review Agents and Complaint Process

- Clarifies that §§ 15-10B and 10D of the Insurance Article apply to HMOs.
- Clarifies that an HMO may not fail to comply with the provisions of § 15-10D of the Insurance Article.
- Clarifies that under certain circumstances a private review agent's grievance decision shall be made based on the professional judgment of:
 - (1) (I) A physician who is board certified or eligible in the same specialty as the treatment under review; or
 - (II) A panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or eligible in the same specialty under review.
 - (3) When the grievance decision involves a mental health or substance service:
 - (I) A licensed physician who:
 - 1. Is board certified or eligible in the same specialty as the treatment under review; or
 - 2. Is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review; or
 - (II) A panel of other appropriate health care service reviewers with at least one physician, selected by the private review agent who:
 - 1. Is board certified or eligible in the same specialty as the treatment under review; or
 - 2. Is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

Effective date: January 1, 2002

HOUSE BILL 190 (Chapter 128) - Health Insurance - Colorectal Cancer Screening - Coverage

- Applies to the following entities:

- (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- An entity subject to HB 190 shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.
 - The coverage required under HB 190 may be subject to a copayment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.
 - Applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after July 1, 2001.

Effective date: July 1, 2001

HOUSE BILL 1042 (Chapter 701) - Health Insurance - Acquisition of Nonprofit Entity

- Amends § 6.5-303 of the State Government Article to repeal a provision that requires the Commissioner to consider whether the acquisition is approved by at least two-thirds of the transferor's certificate holders who have voted on the acquisition for the purpose of determining whether to approve the acquisition of a nonprofit health service plan.
- Establishes that, if the Maryland Health Care Foundation receives a distribution of public or charitable assets as the result of an acquisition of a nonprofit health service plan or a nonprofit health maintenance organization, approved by the Maryland Insurance Administration on or after June 1, 2001, that:
 - (a) (1) There is a Maryland Health Care Trust;
 - (2) The Trust is a body corporate, subject to modification or termination by the General Assembly;
 - (3) The purpose of the Trust is to:
 - (i) be of general benefit to the residents of the State;
 - (ii) be charitable in nature; and

- (iii) to accept and retain moneys for future expenditures to be used to implement Acts of the General Assembly, other than the State budget bill, that:
 - 1. improve the health status of residents of the State; and
 - 2. specifically direct the use of assets of the Trust; and
 - (4) Moneys expended from the Trust are supplemental to, and are not intended to take the place of, State funds that would otherwise be appropriated by the State for the improvement of the health care status of the residents of the State;
- (b)
 - (1) The Maryland Health Care Foundation shall be the Trustee of the Trust; and
 - (2) The powers and duties of the Trust shall rest in and be exercised by the Trustee;
- (c) The powers and duties of the Trust shall be established and modified solely by the General Assembly;
- (d) The Trust consists of the public and charitable assets received by the Maryland Health Care Foundation as a result of the acquisition of a nonprofit health service plan or a nonprofit health maintenance organization, approved by the Maryland Insurance Administration on or after June 1, 2001, in accordance with Title 6.5 of the State Government Article.
- (e) The State Treasurer shall manage, invest, and reinvest the Trust in the same manner as State funds are invested, provided, however, that the Trust shall be held and accounted for separate and apart from the funds of the State;
- (f)
 - (1) Subject to item (2) of this subsection, any interest or other investment earnings of the Trust shall be credited and paid **into** the Trust; and
 - (2) The Trustee shall grant to the Maryland Health Care Foundation any interest and other investment earnings that accrue on the assets of the Trust before July 1, 2002, not exceeding a total of \$10,000,000; and
- (g)
 - (1) The Trustee shall make provision for a system of financial accounting, controls, audits, and reports; and
 - (2) The Trustee shall report to the Governor, and, in accordance with § 2-1246 of the State Government Article, to the General

Assembly on or before December 1, 2001 and annually thereafter on the status of the assets of the Trust.

Effective date: October 1, 2001

HOUSE BILL 1396 (Chapter 329) - Long-Term Care Insurance - Loss Ratios - Premium Increases

- Repeals § 18-115(a) of the Insurance Article which requires benefits under a policy or certificate of long-term care insurance to be considered reasonable in relation to premiums if the expected loss ratio is at least 60 percent and is calculated in a manner that provides for adequate reserving of the long-term care insurance risk.
- Allows for the Maryland Insurance Administration to adopt the NAIC model regulations regarding rate stabilization which permits a lower loss ratio for new contracts.

Effective date: October 1, 2001

HOUSE BILL 1448 (Chapter 563) - Medicare Supplement Policies - Medicare Select Program

- Authorizes an insurer or a nonprofit health service plan that is authorized to issue Medicare Supplement policies under the Insurance Article to issue Medicare Supplement policies under the Medicare Select Program (§ 15-904 of the Insurance Article).
- Establishes that the requirements for a Medicare Supplement policy issued under the Medicare Select Program shall be consistent with the requirements set forth in the Federal Omnibus Budget Reconciliation Act of 1990 and any subsequent relevant federal law and regulations.
- Requires DHMH to determine the adequacy of the network established by an insurer or a nonprofit health service plan under the Medicare Select Program, as to the number of providers, geographic location, hours of operation, promptness of service, and range of services, in the same manner as determined for a health maintenance organization under §§ 19-705.1 and 19-705.2 of the Health-General Article.
- Allows the Commissioner to adopt regulations, in consultation with DHMH, to establish the requirements of the Medicare Select Program.

Effective date: October 1, 2001

PROPERTY AND CASUALTY

SENATE BILL 509 (Chapter 392) - Property and Casualty Insurance - Limitation of Reduction Due to Workers' Compensation Benefits

- Establishes that the benefits payable under the coverages described in §§ 19-505 and 19-509 of the Insurance Article shall be reduced to the extent the recipient has recovered benefits under the workers' compensation laws of a state or the federal government for which the provider of the workers' compensation benefits has not been reimbursed (§ 19-513(e) of the Insurance Article).

Effective date: October 1, 2001

SENATE BILL 797 (Chapter 625) - Property and Casualty Insurers - Geographic Distribution of Private Passenger and Residential Property Premium

- Alters the definition of "major insurer" to mean an insurer or affiliate or subsidiary of that insurer that has written an amount of private passenger premium in the State that totals **one percent** or more of the total premium of private passenger premium written in the State by all insurers, including the Maryland Automobile Insurance Fund.

Effective date: June 1, 2001

HOUSE BILL 148 (Chapter 443) - Boiler and Pressure Vessel Safety - Regulation of Inspectors, Owners, Repair Companies and Insurance Companies

- Among other things, under § 176C of Article 48 - Inspections, an authorized insurer that provides coverage for boiler or pressure vessels is required to conduct the certificate inspection for each covered boiler and pressure vessel that the company insures by the date the inspection is due.
- Enforcement of HB 148 is with the Commissioner of Labor and Industry.

Effective date: June 1, 2001

HOUSE BILL 180 (Chapter 447) - Homeowner's Insurance and Private Passenger Motor Vehicle Insurance - Standards for Cancellation and Nonrenewal - Repeal of Sunset

Repeals the sunset provision that would have repealed Chapter 652 of the Acts of 1998.

Effective date: June 1, 2001

HOUSE BILL 265 (Chapter 209) - Title Insurers - Statements of Financial Condition - Exemption from Filing Requirement

Exempts law firms and individual attorneys practicing in law firms from the requirement under § 10-121(J) of the Insurance Article.

Effective date: October 1, 2001

HOUSE BILL 385 (Chapter 218) - Insurance - Improper Premiums and Charges - Policy Fee Charged by Surplus Lines Brokers

- Establishes different fee limits that can be charged by a surplus lines broker under § 27-216 of the Insurance Article for a personal lines policy and a commercial lines policy.
- Under certain circumstances, a surplus lines broker may charge a reasonable policy fee not exceeding:
 - (I) \$100 on each personal lines policy procured by a qualified agent or qualified broker to whom the surplus lines broker pays a commission;
or
 - (II) \$250 on each commercial lines policy procured by a qualified agent or qualified broker to whom the surplus lines broker pays a commission.

Effective date: October 1, 2001

HOUSE BILL 387 (Chapter 219) - Insurance - Premium Financing

- Requires an agent, broker, or premium finance company to send a copy of the premium finance agreement or other notice of premium to the surplus lines broker when a policy is procured through a surplus lines broker in the State and payment is not made directly to the surplus lines broker or the insurer.
- Permits a premium finance company to require an agent or broker who procures premium financing to:

- (I) send to the surplus lines broker the notice required under § 23-302(B)(1) of the Insurance Article within 10 business days of the execution of the premium finance agreement; and
 - (II) provide to the premium finance company, within 10 business days of receipt of a policy, the insured's name, policy number, and any other information necessary to complete a premium finance agreement.
- Requires an agent or broker to return any gross unearned commissions, calculated as provided in subsection § 23-405(A)(1) of the Insurance Article, to an insurer within a reasonable period of time as required by the insurer.

Effective date: October 1, 2001

HOUSE BILL 1388 (Chapter 327) - Vehicle Laws - Insurance Claim Settlements - Salvage

Among other things, Chapter 327:

- Provides that when possession of a vehicle that is salvage is retained by the owner of the vehicle at the conclusion of a claim settlement by an insurance company, the insurance company is not considered to have acquired the vehicle (§ 11-152 of the Transportation Article).
- Alters the requirements for an insurance company to notify the Motor Vehicle Administration when the company makes a claim settlement on a vehicle that is salvage and retained by the owner under § 13-506 of the Transportation Article.
- Alters certain notice requirements for insurers under § 13-506 of the Transportation Article.

Effective date: July 1, 2001

MISCELLANEOUS

SENATE BILL 592 (Chapter 609) - Workers' Compensation Insurers and Self-Insurers - Office and Personnel Requirements

Among other things, the law sets forth the following provisions:

- Under § 9-405 of the Labor and Employment Article, each employer that self-insures under this law is required to have in the State competent individuals who:

- (I) handle and adjust each disputed workers' compensation claim in the State for the employer; and
 - (II) possess the knowledge and experience to handle and adjust each disputed claim.
- Under § 9-410 of the Labor and Employment Article, an insurer that provides workers' compensation insurance in the State is required to have in the State competent individuals who:
 - (I) handle and adjust each disputed workers' compensation claim in the State for the employer; and
 - (II) possess the knowledge and experience to handle and adjust each disputed claim.

Effective date: October 1, 2001

SENATE BILL 763 (Chapter 426) - Workers' Compensation - Self-Insurance Groups

- Defines "insolvent self-insurance group" under § 25-301 of the Insurance Article to mean a self-insurance group in which each individual member of the group is unable to meet the member's debts as they mature in the ordinary course of business as determined by the Commissioner.
- Clarifies under § 25-304 of the Insurance Article that a self-insurance group shall pay all workers' compensation benefits for which each member incurs liability during its period of membership.
- Clarifies under § 25-304 of the Insurance Article that each member of a self-insurance group is jointly and severally liable for the workers' compensation obligations of the group and its members that are incurred during its period membership.
- Clarifies under § 25-304 of the Insurance Article that a member who elects to terminate its membership in or is canceled by a group remains jointly and severally liable for workers' compensation obligations of the group and its members which were incurred during the canceled or terminated member's period of membership.
- Requires the Maryland Insurance Administration to report to the Senate Finance Committee and the House Economic Matters Committee, on or before December 1, 2001, on the following:
 - (1) the name of each workers' compensation self-insurance group, the type of businesses that generally become members of each group, the

number of employers that belong to each group, and the total number of employees that are served by each group;

- (2) the status of the regulation and operation of the workers' compensation self-insurance groups; and
- (3) any recommendations for changes to the law regarding the regulation of workers' compensation self-insurance groups.

Effective date: October 1, 2001

SENATE BILL 837 (Chapter 434) - Insurance - Insurance Insolvencies - Claims Priority

- Alters the priority of distribution in the event of an insurer insolvency when there are known or potential claims due the federal government.
- Prioritizes claims of guaranty corporations before claims of the federal government.

Effective date: October 1, 2001

SENATE BILL 865 (Chapter 174) - Dental Plan Organizations - Solvency Requirements

- Alters the circumstances under which a dental plan organization is exempted from § 14-404 of the Insurance Article to include the following provision:
 - (l) did not have any enrollees as of January 1, 2000;
- Provides that a dental plan organization does not qualify for exemption from the provisions of § 14-404 of the Insurance Article if the dental plan organization has one or more enrollees on or after January 1, 2000.

Effective date: October 1, 2001

HOUSE BILL 153 (Chapter 51) - Insurance - Risk Based Capital Standards for Insurers - Exemption

Authorizes the Commissioner to exempt certain health insurers from the application of the risk based capital standards set forth in Title 4 of the Insurance Article.

Effective date: July 1, 2001

HOUSE BILL 283 (Chapter 652) - Insurance - Late Fees and Installment Fees

- Under certain circumstances, HB 283 allows an authorized insurer to charge and collect, if approved by the Insurance Commissioner, reasonable installment fees or late fees for late payment of premiums by policyholders or both.
- Requires the Insurance Commissioner to review administrative expenses submitted by an authorized insurer that are associated with late payments or installment payments.
- Authorizes the Insurance Commissioner to approve a late fee or installment fee of not more than \$10.
- Prohibits the imposition of a late fee:
 1. During any grace period required by law or regulation on a policy of insurance; or
 2. If no grace period is required by law or regulation on a policy of insurance, until two business days after the date the payment amount becomes due.
- Requires an authorized insurer to credit each payment received from an insured to the premium owed by the insured before crediting the payment to a late fee or installment fee owed by the insured.
- Prohibits the cancellation of a policy of insurance for the failure to pay a single late fee or installment fee.

Effective date: October 1, 2001

HOUSE BILL 362 (Chapter 469) - Maryland Insurance Administration - Adoption of Regulations

- Requires the Insurance Commissioner to promulgate regulations that establish standards governing the privacy of consumer financial and health information pursuant to Title V of the Federal Financial Services Modernization Act of 1999.
- Requires the regulations promulgated in accordance with § 2-109(D)(1) to be consistent with the provisions of the model regulation adopted by the National Association of Insurance Commissioners entitled, "Privacy of Consumer Financial and Health Information Regulation".

- The regulations adopted in accordance with § 2-109(d) of the Insurance Article may not take effect before January 1, 2002.
- Requires the Insurance Commissioner to establish criteria and a process to allow an individual who is otherwise prohibited from engaging in or participating in the business of insurance under the Federal Violent Crime Control and Law Enforcement Act of 1994 to obtain written consent from the Commissioner to engage in or participate in the business of insurance under the Federal Act.

Effective date: July 1, 2001

HOUSE BILL 937 (Chapter 285) - Financial Guaranty Insurance Companies - Definition and Home Office Requirement

- Alters the definition of a "financial guaranty insurance company" to allow certain financial guaranty insurance companies to have a home or executive office outside the State under certain circumstances.

Effective date: July 1, 2001

HOUSE BILL 1412 (Chapter 332) - Insurance - Assets, Reserves, and Investments of Insurers

- Alters the assets owned by an insurer that are required to be allowed as admitted assets under § 5-101(a) of the Insurance Article.
- For the purpose of determining the financial condition of an insurer, alters the items related to investments, securities, properties, or loans that the insurer owns that are required to be allowed as admitted assets under § 5-101(b) of the Insurance Article.
- Alters the assets that are not allowed as admitted assets under § 5-102(a) of the Insurance Article.
- Repeals § 5-204 of the Insurance Article, which governs loss reserves for certain liability and workers' compensation insurance.
- Alters the manner in which reserves are computed under § 5-205 of the Insurance Article.
- Alters the reserve requirements for a title insurer under § 5-206 of the Insurance Article.

- Alters from 15 percent to ten percent or more under which an insurer that owns stock of another insurer must have its stock valued at book value under § 5-401(b) of the Insurance Article.
- Alters § 5-401(d) of the Insurance Article as to the valuation of real estate investments of insurers.
- Alters § 5-508 of the Insurance Article to allow a life insurer to lend to its policyholder on the policy as collateral security an amount not exceeding the **cash surrender value** of the policy.

Effective date: October 1, 2001