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Governor

ANTHONY G. BROWN
Lt. Governor

MARYLAND INSURANCE ADMINISTRATION

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BULLETIN 07-11

To: **Insurers, Non-Profit Health Service Plans, and Health Maintenance Organizations**

Re: **Summary of 2007 Insurance Legislation Signed into Law by Governor Martin O'Malley**

Date: **July 2007**

This summary is meant to place insurers, non-profit health service plans, and health maintenance organizations authorized to do business in Maryland on notice of certain laws passed in the 2007 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration (MIA). ***The attached synopsis is intended to serve only as notice of the passage of the legislation and not intended to be a guide to the MIA's interpretation or enforcement of the legislation.*** All insurers, non-profit health service plans, and health maintenance organizations should refer to the 2007 Chapter Laws of Maryland for the complete text of any of these recently enacted laws. Insurers, non-profit health service plans, and health maintenance organizations are advised that other bills passed by the General Assembly and not listed on the synopsis may also affect their business operations in Maryland.

You can obtain a copy of a specific law passed by the General Assembly during the 2007 legislative session by accessing 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 "mlis" web site. You can also obtain a copy of *The 90 Day Report -- A Review of the 2007 Legislative Session* from Library and Information Services, Office of Policy Analysis, Department of Legislative Services, 90 State Circle, Annapolis, MD 21401-1991 (410-946-5400).

For additional information concerning the Maryland Insurance Administration's Summary of 2007 Insurance Legislation, please contact Kimberly Y. Robinson, Esq., Director of Government Relations, at 410-468-2202.

2007 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 157 (Chapter 591) – Health Insurance – Prohibited Discrimination and Rebates – Incentives for Participation in Wellness Programs and Other Exceptions

- Specifies that it is not discrimination or a rebate for a carrier to provide reasonable incentives to an individual who is an insured, a subscriber, or a member for participation in a bona fide wellness program offered by the carrier if:

  (1) The carrier does not make participation in the bona fide wellness program a condition of coverage under a policy or contract;

  (2) participation in the bona fide wellness program is voluntary and a penalty is not imposed on an insured, subscriber, or member for nonparticipation;

  (3) an insured, subscriber, or member is not required to achieve any specific outcome in order to receive an incentive for participation in the bona fide wellness program; and

  (4) the carrier does not market the bona fide wellness program in a manner that reasonably could be construed to have as its primary purpose the provision of an incentive or inducement to purchase coverage from the carrier.

- Requires that any incentive offered for participation in a bona fide wellness program:

  (1) shall be reasonably related to the bona fide wellness program; and

  (2) may not have a value that exceeds any limit established in regulations adopted by the Commissioner.

- Requires the Commissioner to adopt regulations to implement the provisions of this subsection.

Effective Date: October 1, 2007

HOUSE BILL 248 (Chapter 23) / SENATE BILL 236 (Chapter 22) – Life Insurance – Investment Accounts

- Removes the definition of a "qualified plan" from § 5-512 of the Insurance Article.

- Permits a life insurer to allocate to one or more separate investment accounts, in accordance with a written agreement, any amounts paid to the life insurer that are to be invested by the life insurer, in accordance with the agreement, and applied to the purchase of guaranteed income benefits under the life insurer's individual or group policies or annuity contracts or to provide other guaranteed benefits incidental to those policies or annuity contracts.

  Effective Date: July 1, 2007

HOUSE BILL 339 (Chapter 600) – <u>Health Insurance – Small Group Market – Health Benefit Plans – Rates</u>

- Permits carriers to offer a discount not to exceed 20% to a small employer for participation in a wellness program.

- Requires that any discount for participation in a wellness program be:

  (1) applied to reduce the rate otherwise payable by the small employer;

  (2) actuarially justified;

  (3) offered uniformly to all small employers; and

  (4) approved by the Commissioner.

- Permits a carrier to charge a rate that is 40% above or 50% below the community rate based on the adjustments allowed under § 15-1205(a)(2) of the Insurance Article.

- Requires that, on or before October 1, 2007, the Maryland Health Care Commission ("Commission") shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under Title 15, Subtitle 12 of the Insurance Article.

- Requires that, on or before January 1, 2011, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the effect of the 50% rate adjustment authorized under House Bill 339 on participation in health benefit plans issued, delivered, or renewed under Title 15, Subtitle 12 of the Insurance Article.

- Provides that the bill shall sunset and be of no further force and effect after June 30, 2011.

  Effective Date: July 1, 2007

HOUSE BILL 487 (Chapter 609) – <u>Nonprofit Health Service Plans – Boards of Directors – Term Limits and Compensation</u>

- Increases the maximum number of terms that may be served by a member of the Board of Directors of a nonprofit health service plan from two to three and increases the maximum number of years of service on the Board from six to nine.

- Removes from the statute the dollar limit on the compensation that a Board member may receive.

- Permits Board members to receive reimbursement for ordinary and necessary expenses and an amount of base compensation and compensation for attendance at meetings in accordance with § 14-139 of the Insurance Article.

- Requires that, on or before June 30 of each calendar year, a corporation subject to this paragraph shall report to the Commissioner on:

  (1) the total amount of base compensation, compensation for attendance at meetings, and reimbursement for ordinary and necessary expenses paid to each Board member in the preceding calendar year; and

  (2) the proposed annual compensation, together with necessary supporting documentation, to be paid to Board members for the next calendar year.

- Requires the compensation committee of the Board to develop proposed guidelines, for approval by the Board, for compensation for Board members that is reasonable in comparison to compensation for Board members of similar nonprofit health service plans.

- Requires the Board to:

  (1) review the guidelines at least annually;

  (2) provide a copy of the approved guidelines to each Board member of the nonprofit health service plan;

  (3) on or before September 1, 2004, and annually thereafter, provide a copy of the approved guidelines to the Commissioner; and

  (4) adhere to the approved guidelines in compensating the Board members of the nonprofit health service plan.

- Requires that, on an annual basis, the Commissioner shall review the base compensation and compensation for attendance at meetings paid by the nonprofit health service plan to Board members.

Effective Date: October 1, 2007

HOUSE BILL 515 (Chapter 612) – <u>Health Insurance – Credentialing Intermediaries and Uniform Credentialing Form</u>

- Exempts from the provisions of § 15-112 (d)(3)(iii) of the Insurance Article a carrier that uses a credentialing intermediary that:

  (1) is a hospital or academic medical center;

  (2) is a participating provider on the carrier's provider panel; and

  (3) acts as a credentialing intermediary for that carrier for health care practitioners that:

    (a) participate on the carrier's provider panel; and

    (b) have privileges at the hospital or academic medical center.

- Removes a requirement that the Commissioner designate the uniform credentialing form through regulation.

- Exempts from the provisions of § 15-112.1(b) of the Insurance Article a hospital or academic medical center that:

  (1) is a participating provider on the carrier's provider panel; and

  (2) acts as a credentialing intermediary for that carrier for health care practitioners that:

    (a) participate on the carrier's provider panel; and

    (b) have privileges at the hospital or academic medical center.

- Removes the requirement that the Commissioner adopt regulations to implement § 15-112.1 of the Insurance Article and substitutes permission for the Commissioner to adopt regulations to implement § 15-112.1 of the Insurance Article.

  Effective Date: June 1, 2007

HOUSE BILL 519 (Chapter 142) / SENATE BILL 263 (Chapter 141) – <u>Health Insurance – Carrier Provider Panels – Nonphysician Specialists</u>

- Alters § 15-830(d) of the Insurance Article to clarify that each carrier shall establish and implement a procedure by which a member may request a referral to a nonphysician specialist who is not part of the carrier's provider panel.

Effective Date: ***October 1, 2007*** *(Applies to policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2007)*

HOUSE BILL 572 (Chapter 613) – <u>Health Insurance – Personal Responsibility – Study</u>

- Requires the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene, the Maryland Insurance Administration, the Health Services Cost Review Commission, and the Office of the Comptroller, to study the issue of personal responsibility for obtaining health care coverage.

- Requires that the study address:

  (1) the affordability of health insurance, particularly for individuals without employer-sponsored coverage;

  (2) the need to subsidize health insurance for individuals with low income, in other financially difficult situations, or with health conditions that hinder the purchase of insurance in the commercial market;

  (3) the use of incentives, such as a child and dependent care tax credit or an income tax surcharge, to encourage individuals to purchase health insurance, and what the level of the incentives would have to be to result in the increased purchase of health insurance;

  (4) public and private strategies to educate individuals and employers about the importance of health coverage;

  (5) whether individual responsibility should be accompanied by some form of employer responsibility;

  (6) enforcement issues, including alternative approaches to the reporting and verification of health care coverage;

  (7) potential reductions in inpatient and outpatient uncompensated care and government expenditures that may result from various personal responsibility provisions; and

  (8) the need for religious exemptions from any proposed health care coverage requirement.

- Requires that, on or before December 1, 2007, the Commission shall report the findings of its study, together with any recommendations, to the Governor and, in

accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

Effective Date: July 1, 2007

HOUSE BILL 579 (Chapter 243) – <u>Health Insurance – Authorization of Additional Products and Small Group Administrative Discounts and Study</u>

- Permits the Commissioner to authorize an insurer or nonprofit health service plan to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the insurer or nonprofit health service plan:

  (1) has demonstrated to the Secretary of Health and Mental Hygiene that the provider panel of the insurer or nonprofit health service plan complies with the regulations adopted under § 19-705.1(b)(1)(ii) of the Health - General Article; and

  (2) does not restrict payment for covered services provided by nonpreferred providers:

    (a) for emergency services, as defined in § 19-701 of the Health - General Article;

    (b) for an unforeseen illness, injury, or condition requiring immediate care; or

    (c) as required under § 15-830 of the Insurance Article.

- Specifies that if an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through preferred providers, then the insurer or nonprofit health service plan with which the employer, association, or other private group arrangement is contracting for the coverage shall offer an option to include preferred and nonpreferred providers as an additional benefit for an employee or individual, at the employee's or individual's option, to accept or reject.

- Specifies that a disclosure statement be included on the group application that an option to include preferred and nonpreferred providers is available for the individual or employee to accept or reject.

- Permits an employer, association, or other private group arrangement to require an employee or individual who accepts the additional coverage for preferred and nonpreferred providers to pay a premium greater than the amount of the premium for the coverage offered for preferred providers only.

- Requires a carrier that is an insurer or nonprofit health service plan that offers a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers to adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19-705.1(b)(1)(ii) of the Health - General Article and as enforced by the Secretary of Health and Mental Hygiene.

- Authorizes the creation of a limited benefit group health insurance contract issued only by an insurer or nonprofit health service plan to an employer if the limited group health insurance contract is issued to provide health coverage only for:

  (1) special eligible employees; or

  (2) special eligible employees and their dependents.

- Specifies what requirements an insurer or nonprofit health service plan that sells a limited benefit group health insurance contract may place on an employer as a condition of sale.

- Specifies the provisions of the Insurance Article with which a limited benefit group health insurance contract shall comply.

- Requires an insurer or nonprofit health service plan to disclose in the group certificate and in enrollment material provided to each special eligible employee that the limited benefit group health insurance contract does not provide comprehensive health coverage.

- Permits a carrier to offer an administrative discount to a small employer if the small employer elects to purchase for its employees an annuity, dental insurance, disability insurance, life insurance, long-term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

- Requires the administrative discount to be offered under the same terms and conditions for all qualifying small employers.

- Requires the Maryland Health Care Commission to:

  (1) conduct a study of the comprehensive standard health benefit plan for the small group health insurance market; and

  (2) on or before December 1, 2007, report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2-1246 of the State Government Article, on options available, including modifying the comprehensive standard health benefit plan to specify a separate in-network deductible, out-of-network deductible, in-network out-of-pocket maximum, and out-of-network out-of-pocket maximum, to reform the

comprehensive standard health benefit plan in a manner that will encourage more employers to enter the small group market.

Effective Date: October 1, 2007

HOUSE BILL 788 (Chapter 26) / SENATE BILL 269 (Chapter 25) – <u>Health Insurance – Collection of Racial and Ethnic Data – Nondiscrimination</u>

- Permits a health insurer, an insurer that provides health insurance, nonprofit health service plan, or health maintenance organization to make an inquiry about race and ethnicity in an insurance form, questionnaire, or other manner requesting general information, provided the information is used solely for the evaluation of quality of care outcomes and performance measurements, including the collection of information required under § 19-134 of the Health - General Article.

- Prohibits an insurer that provides health insurance, nonprofit health service plan, or health maintenance organization from using race or ethnicity data to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract.

- Permits the Commissioner to issue an order under §§ 4-113, 4-114, 27-501, and 27-505 of the Insurance Article if the Commissioner finds a violation of § 27-914 of the Insurance Article.

Effective Date: October 1, 2007

HOUSE BILL 847 (Chapter 629) – <u>Discount Medical Plan Organizations and Discount Drug Plan Organizations – Registration and Regulation</u>

- Creates Title 14, Subtitle 6 “Discount Medical Plan Organizations and Discount Drug Plan Organizations“ within the Insurance Article, which:

  (1) specifies specific exemptions for insurers, nonprofit health service plans, health maintenance organizations and dental plans that sell, market or solicit a discount medical plan or discount drug plan in the State;

  (2) specifies requirements for registration of discount medical plan organizations and discount drug plan organizations;

  (3) specifies when the Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant;

  (4) prohibits certain actions of a discount medical plan organization or a discount drug plan organization;

(5) requires certain disclosures be made by a discount medical plan organization or discount drug plan organization;

(6) specifies cancellation requirements for a discount medical plan or discount drug plan;

(7) requires the issuance of a card and specifies data elements that must be included on a discount medical plan card or discount drug plan card;

(8) authorizes the Commissioner to examine the affairs, transactions, accounts, records, and assets of a discount medical plan organization or discount drug plan organization;

(9) specifies the manner in which the Commissioner may enforce Title 14, Subtitle 6 of the Insurance Article; and

(10) requires the Commissioner to adopt regulations to carry out the requirements of Title 14, Subtitle 6 of the Insurance Article.

- Requires the expense incurred in an examination made by the Commissioner under § 14-610 of the Insurance Article for discount medical plan organizations and discount drug plan organizations be paid by the person examined

Effective Date: October 1, 2007

HOUSE BILL 947 (Chapter 169) / SENATE BILL 601 (Chapter 168) – <u>Health Insurance – Health Care Providers – Reimbursement and Charges</u>

- Prohibits a carrier from requiring a provider that provides health care services through a group practice or health care facility that participates on the carrier's provider panel under a contract with the carrier to be considered a participating provider or to accept the reimbursement fee schedule applicable under the contract when:

(1) providing health care services to enrollees of the carrier through an individual or group practice or health care facility that does not have a contract with the carrier; and

(2) billing for health care services provided to enrollees of the carrier using a different federal tax identification number than that used by the group practice or health care facility under a contract with the carrier.

- Requires a nonparticipating provider to notify an enrollee:

(1) that the provider does not participate on the provider panel of the enrollee's carrier; and

(2) of the anticipated total charges for the health care services.

Effective Date: October 1, 2007

HOUSE BILL 1033 (Chapter 638) – <u>Health Insurance – Prescription Drugs and Devices – Copayment or Coinsurance</u>

- Prohibits (1) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under health insurance policies or contracts that are issued or delivered in the State and (2) health maintenance organizations that provide coverage for prescription drugs and devices under contracts that are issued or delivered in the State, including an insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefit manager, from imposing a copayment or coinsurance requirement for a covered prescription drug or device that exceeds the retail price of the prescription drug or device.

Effective Date: October 1, 2007

HOUSE BILL 1057 (Chapter 639) – <u>Health Insurance – Family Coverage Expansion Act</u>

- Creates a definition of "child dependent" in § 15-403.2 of the Insurance Article.

- Requires each individual or group policy or contract issued by an insurer, nonprofit health service plan or health maintenance organization in the State to provide that the same health insurance benefits and eligibility guidelines that apply to any covered dependent are available to a domestic partner of an insured or a child dependent of the domestic partner of an insured at the request of:

  (1) an insured under an individual policy or contract that is subject to § 15-403.2 of the Insurance Article; or

  (2) the group policy holder of a group policy or contract that is subject to § 15-403.2 of the Insurance Article.

- Permits an insurer, nonprofit health service plan, or health maintenance organization to require a group policy holder that requests coverage for a domestic partner or child dependent of the domestic partner of an insured to provide proof of the eligibility of the domestic partner or child dependent of the domestic partner for coverage.

- Requires the Commissioner to adopt regulations to implement §15-403.2 of the Insurance Article.

- Requires that, at least 60 days before a child who is covered under a parent's individual, group, or blanket health insurance policy turns 18 years of age, an entity subject to § 15-416 of the Insurance Article shall:

  (1) notify the parent of criteria under which a child may remain eligible for coverage as a dependent under the policy or contract; and

  (2) provide information regarding:

    (a) any other policies that may be available to the child from the entity; and

    (b) the availability of additional information from the Administration regarding individual policies in the State.

- Requires the Commissioner to establish and publish by bulletin the notice to be given under § 15-416 of the Insurance Article.

- Adds a new definition of the term "child dependent," which includes certain children who are younger than 25 years of age.

- Requires that each policy or contract that provides coverage for dependents issued by an insurer, nonprofit health service plan or health maintenance organization shall:

  (1) include coverage for a child dependent;

  (2) provide the same health insurance benefits to a child dependent that are available to any other covered dependent; and

  (3) provide health insurance benefits to a child dependent at the same rate or premium applicable to any other covered dependent.

- Specifies that § 15-418 of the Insurance Article does not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in the Insurance Article.

- Requires that:

  (1) on or before November 1, 2007 the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene and the Maryland Insurance Administration, shall study the high rate of uninsurance among young adults ages 19 to 29 in the State and recommend to the Senate

Finance Committee and the House Health and Government Operations Committee ways to increase health care coverage; and

(2) the study shall include a review of current health care coverage options available in the State and options available in other states and shall examine in particular:

(a) ways to provide health care coverage to young adults transitioning from foster care; and

(b) the feasibility and desirability of a Medicaid or Maryland Children's Health Program buy-in, including *any potential for adverse selection that such a buy-in might create*.

Effective date: ***June 1, 2007*** *(Applies to policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2008)*

HOUSE BILL 1082 (Chapter 452) – <u>Managed Care Organizations – Retroactive Denial of Claims and Applicability of State Laws</u>

- Specifies that, except as otherwise provided in Title 15, subtitle 1 of the Health - General Article, a managed care organization is not subject to the insurance laws of the State or to the provisions of Title 19 of the Health - General Article.

- Specifies that the provisions of §§ 4-311, 15-604, 15-605, and 15-1008 of the Insurance Article shall apply to managed care organizations in the same manner they apply to carriers.

- Exempts from timeframes limiting retroactive denial of reimbursement a claim submitted to a managed care organization if the claim was for services provided to a Maryland Medical Assistance Program recipient during a time period for which the Program has permanently retracted the capitation payment for the Program recipient from the managed care organization.

Effective Date: ***July 1, 2007*** *(Applies to claims paid by Maryland Medical Assistance Program to managed care organizations on or after July 1, 2007)*

HOUSE BILL 1160 (Chapter 29) / SENATE BILL 335 (Chapter 28) – <u>Qualified State Long-Term Care Insurance Partnership – Revisions</u>

- Changes the name of the "Maryland Partnership for Long-Term Care Program" to the "Qualified State Long-Term Care Insurance Partnership."

- Specifies that the Qualified State Long-Term Care Insurance Partnership shall comply with the requirements of § 1917(b) of the Social Security Act and any applicable federal guidelines.

- Removes the requirement that to be eligible for the Qualified State Long-Term Care Insurance Partnership the individual must have exhausted all benefits available under the policy that are available for services to treat or manage the insured's condition.

- Removes the requirements that, in order to qualify for the Qualified State Long-Term Care Partnership, a long-term care policy shall (1) provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion and (2) provide the management information and reports necessary to document the extent of resource protection offered and to evaluate the Program.

- Removes a requirement that the Department of Health and Mental Hygiene may not approve a long-term care policy if the policy requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

- Alters the due dates of specified legislative reports.

Effective Date: June 1, 2007

HOUSE BILL 1283 (Chapter 467) – <u>Maryland Health Insurance Plan - Authority</u>

- Permits the Board of Directors of the Maryland Health Insurance Plan to offer members an optional endorsement to remove the preexisting condition limitation if the Board has implemented a preexisting condition limitation.

- Permits the Board to charge an actuarially justified additional premium amount in addition to the premium rate for the standard benefit package for the optional endorsement removing the preexisting condition limitation.

- Specifies that an amount charged in addition to the premium rate for the standard benefit package for the optional endorsement removing the preexisting condition limitation shall be subject to review and approval by the Commissioner.

- Permits the Board to charge different premiums based on the cost-sharing arrangement when more than one cost-sharing arrangement is offered.

Effective date: May 8, 2007

HOUSE BILL 1313 (Chapter 646) – <u>Department of Health and Mental Hygiene – Maryland Medical Assistance Program – Information from and Liability of Health Insurance Carriers</u>

- Adds new requirements for carriers, which are defined to include:

  (1) Health insurers;

  (2) Nonprofit health service plans;

  (3) Health maintenance organizations;

  (4) Dental plan organizations; and

  (5) Any other person included as a third party in §1902(a)(25)(a) of the Social Security Act, as amended by the Federal Deficit Reduction Act of 2005.

- Requires a carrier to provide, at the request of the Department of Health and Mental Hygiene, information about individuals who are eligible for benefits under the Medicaid program or are program recipients so that the Department may determine whether an individual, the spouse of an individual, or the dependent of an individual is receiving health care coverage from a carrier and the nature of that coverage.

- Requires a carrier to provide the information required in a manner prescribed by the Department.

- Requires a carrier to accept the program's right of recovery and the assignment to the program of any right of an individual or other entity to payment from the carrier for an item or service for which payment has been made under the program if the carrier has a legal obligation to make payment for the item or service.

- Requires that, as a condition of doing business in the State, a carrier shall comply with the requirements set forth in § 42 U.S.C. 1396a(a)(25)(i)(i) through (iv).

- Specifies that a carrier subject to § 15-144 of the Health-General Article may not reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract for a reason based wholly or partly on:

  (1) the eligibility of the individual for receiving benefits under the program; or

  (2) the receipt by an individual of benefits under the program.

  Effective Date: June 1, 2007

HOUSE BILL 1370 (Chapter 509) / SENATE BILL 824 (Chapter 508) – Senior Prescription Drug Assistance Program – Modifications and Sunset Extension

- Extends the subsidy that a nonprofit health service plan is required to make to the Senior Prescription Drug Assistance Program from fiscal year 2008 to fiscal year 2010.

- Specifies that the subsidy that a nonprofit health service plan is required to make to the Senior Prescription Drug Assistance Program may not exceed the lesser of:

  (1) $14,000,000 for fiscal years 2008 through 2010, and

  (2) the value of the nonprofit health service plan's premium tax exemption under § 6–101(b) of the Insurance Article for any year.

- Permits the Senior Prescription Drug Assistance Program to limit its payment of Medicare Part D subsidies to payments only on behalf of eligible individuals who are enrolled in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan that coordinates with the Senior Prescription Drug Assistance Program in accordance with federal requirements.

- Corrects references to the Senior Prescription Drug Assistance Program and its effective date in Chapter 153 of the Acts of 2002, as amended by Chapter 282 of the Acts of 2005 and Chapter 345 of the Acts of 2006.

- Extends the Senior Prescription Drug Assistance Program until December 31, 2009.

  Effective Date: June 1, 2007

SENATE BILL 107 (Chapter 505) – Task Force on Health Care Access and Reimbursement

- Creates the Task Force on Health Care Access and Reimbursement.

- Specifies the Task Force membership consists of:

  (1) two members of the House of Delegates, appointed by the Speaker of the House;

  (2) two members of the Senate of Maryland, appointed by the President of the Senate;

  (3) the Secretary of Health and Mental Hygiene;

(4) the Attorney General, or the Attorney General's designee;

(5) the Insurance Commissioner, or the Insurance Commissioner's designee;

(6) the Secretary of Budget and Management, or the Secretary's designee; and

(7) six individuals appointed by the Governor.

- Permits the Task Force to consult with individuals and entities that the Secretary of Health and Mental Hygiene deems appropriate.

- Requires the Secretary of Health and Mental Hygiene to:

(1) chair the Task Force;

(2) establish subcommittees and appoint subcommittee chairs as necessary to facilitate the work of the Task Force; and

(3) provide staff support for the Task Force from the Department of Health and Mental Hygiene.

- Requires that the Task Force shall invite all interested groups, including physician groups, health care provider specialty groups, employers, and health insurance carriers, to present testimony or other information to the Task Force concerning:

(1) the issues to be studied by the Task Force;

(2) data on the reimbursements paid to physicians and other health care providers by health insurance carriers;

(3) trends relating to reimbursement rates and total payments to physicians and other health care providers by health insurance carriers; and

(4) data and trends in physician and other health care provider workforce supply and future demand.

- Requires the Task Force to examine**:**

(1) reimbursement rates and total payments to physicians and other health care providers by specialty and geographic area and trends in such reimbursement rates and total payments, including a comparison of reimbursement rates, total payments, and trends in other states;

(2) the impact of changes in reimbursements on access to health care and on health care disparities, volume of services, and quality of care;

(3) the effect of competition on payments to physicians and other health care providers;

(4) the trends for physician and other health care provider shortages by specialty and geographic area and any impact on health care access and quality caused by such shortages, including emergency department overcrowding;

(5) the amount of uncompensated care being provided by physicians and other health care providers and the trends in uncompensated care in Maryland and in other states;

(6) the extent to which current reimbursement methods recognize and reward higher quality of care;

(7) methods used by large purchasers of health care to evaluate adequacy and cost of provider networks; and

(8) the practice by certain health insurance carriers of requiring health care providers who join a provider network of a carrier to also serve on a provider network of a different carrier; and the effect of the practice on health care provider payments and willingness to serve on provider networks of health insurance carriers.

- Requires the Task Force to develop recommendations regarding:

(1) specific options that are available, given limitations of the federal ERISA law, to change physician and other health care provider reimbursements, if needed;

(2) the sufficiency of present statutory formulas for the reimbursement of noncontracting physicians and other health care providers by health maintenance organizations;

(3) whether the Maryland Insurance Administration and the Attorney General currently have sufficient authority to regulate rate setting and market-related practices that may have the effect of unreasonably reducing reimbursements;

(4) whether there is a need to enhance the ability of physicians and other health care providers to negotiate reimbursement rates with health insurance carriers, without unduly impairing the ability of the carriers to appropriately manage their provider networks;

(5) whether there is a need to establish a rate-setting system for physicians and other health care providers similar to the system established to set hospital rates in Maryland;

(6) the advisability of the use of payment methods linked to quality of care or outcomes; and

(7) the need to prohibit a health insurance carrier from requiring health care providers who join a provider network of the carrier to also serve on a provider network of a different carrier.

- Requires the Task Force to report its findings and recommendations to the Governor and to the General Assembly, on or before December 31, 2007.

- Requires that if the Task Force determines it will not complete its work by December 31, 2007, the Task Force shall:

(1) submit an interim report of its findings and recommendations on or before December 1, 2007;

(2) submit its findings and recommendations relating to the need to prohibit a health insurance carrier from requiring health care providers who join a provider network of the carrier to also serve on a provider network of a different carrier on or before December 31, 2007; and

(3) submit a final report of its findings and recommendations on or before June 30, 2008.

Effective Date: July 1, 2007

SENATE BILL 952 (Chapter 59) – <u>Health Insurance – Small Group Market – Choice of Policies for Sole Proprietors</u>

- Permits each individual enrolled on September 30, 2005 in a health benefit plan offered by a carrier under Title 15, Subtitle 12 of the Insurance Article, at the option of the enrollee, to remain covered under any policy issued by the carrier to small employers and selected by the enrollee at renewal, subject to the termination provisions under § 15-1212(b) of the Insurance Article, provided the enrollee continues to:

(1) work and reside in the State; and

(2) be a self-employed individual organized as a sole proprietorship or in any other legally recognized manner that a self-employed individual may organize:

(a) a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(b) who has filed the appropriate Internal Revenue form or forms and schedule for the previous taxable year; and

(c) for whom a copy of the appropriate Internal Revenue form or forms and schedule has been filed with the carrier.

Effective Date: July 1, 2007

SENATE BILL 1022 (Chapter 586) – Group Life Insurance – Additional Insureds – Domestic Partners

- Specifies that insurance under a policy of group life insurance issued in accordance with §§ 17-201 through 17-205 of the Insurance Article may be extended to cover a domestic partner of each insured employee or member who elects to obtain the coverage.

- Specifies that the term "domestic partner" has the meaning stated in the policy.

Effective Date: October 1, 2007

PROPERTY AND CASUALTY

HOUSE BILL 372 (Chapter 175) / SENATE BILL 651 (Chapter 174) – Medical Malpractice Insurance – Garrett County Memorial Hospital – Subsidy for Family Practitioners Who Also Perform Obstetrical Services

- Permits a medical professional liability insurer to seek reimbursement from the Rate Stabilization Account, for medical professional liability insurance policies issued to family practitioners who have staff privileges at Garrett County Memorial Hospital and who also provide obstetrical services at Garrett County Memorial Hospital, an amount equal to 75% of the difference between the policyholder's premium for calendar year 2007, 2008, and 2009 and the premium that otherwise would be payable in those calendar years if the policyholder was not providing obstetrical services.

Effective Date: July 1, 2007

HOUSE BILL 1187 (Chapter 88) - Motor Vehicle Liability Insurance – Exclusion of Named Driver

- Amends the law to expressly permit, but not require, an insurer to offer to exclude coverage for a named individual driver in lieu of effecting a lawful premium increase, cancellation, or nonrenewal of a policy of motor vehicle

liability insurance that covers more than one individual (other than a policy of private passenger motor vehicle insurance) as a result of the claims experience or driving history of the named individual.

- Clarifies that the obligation of an insurer to offer to exclude coverage for a named individual driver in lieu of effecting a lawful premium increase, cancellation, or nonrenewal of a policy of motor vehicle liability insurance that covers more than one individual as a result of the claims experience or driving history of the named individual applies only to a policy of private passenger motor vehicle insurance.

Effective Date: October 1, 2007

HOUSE BILL 1442 (Chapter 486) – <u>Task Force on the Availability and Affordability of Property Insurance in Coastal Areas</u>

- Creates the Task Force to study the Availability and Affordability of Property Insurance in Coastal Areas in Maryland.

- Specifies that the Task Force consists of:

  (1) one member of the Senate Finance Committee, appointed by the Chair of the Committee;

  (2) three members of the House Economic Matters Committee, appointed by the Chair of the Committee;

  (3) the Maryland Insurance Commissioner or the Commissioner's designee; and

  (4) the People's Insurance Counsel or the Insurance Counsel's designee.

- Requires the Chair of the Senate Finance Committee and the Chair of the House Economic Matters Committee jointly to appoint co-chairs of the Task Force from among the Senate and House members appointed to the Task Force.

- Requires the Maryland Insurance Administration to provide staff for the Task Force.

- Specifies that the purpose of the Task Force is to examine methods to ensure the continued availability and affordability of property insurance in coastal areas of Maryland.

- Requires that, in examining methods to ensure the continued availability and affordability of property insurance in coastal areas of Maryland, the Task Force shall study:

(1) the availability and affordability of homeowner's insurance and other property insurance in coastal areas of the State, including the Eastern Shore and Southern Maryland, and whether there is sufficient competition within those areas;

(2) the current number and types of insurers in the coastal markets, including admitted carriers, excess and surplus lines carriers, residual market mechanisms, captives, and the reinsurance market, and the types of products offered;

(3) the competition and rate adequacy in the coastal markets for storm-related perils;

(4) the impact of coastal markets on the availability and affordability of property insurance in noncoastal areas and the costs associated with spreading property insurance risks among homeowners across the entire State;

(5) the regulatory framework within the State for the pricing and underwriting of property insurance, including the use of named storm deductibles;

(6) the development and evolution of storm modeling and its use by the insurance industry in the assessment of potential losses from significant storms and the need for a regulatory framework in the use of storm modeling;

(7) potential structural protections for properties in coastal areas that would result in the mitigation of storm damage in coastal areas and the extent to which such mitigation has had a beneficial impact on the availability and affordability of property insurance in other states;

(8) the ability of the State to influence patterns of real estate development in coastal areas in a manner that minimizes future exposure of the State and Maryland residents to severe storm damage to property;

(9) the effectiveness, cost, and long-term viability of alternative market mechanisms, such as limited coverage products, wind pools, the expansion of residual market mechanisms, and catastrophe funds that have been implemented or are being considered in other states or by the federal government;

(10) initiatives adopted in other states to increase availability and affordability of property insurance in coastal areas; and

(11) any other matter the Maryland Insurance Commissioner deems relevant to the availability and affordability of homeowner's insurance in coastal areas of the State.

- Requires that on or before December 31, 2007, the Task Force shall report on its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Economic Matters Committee.

Effective Date: June 1, 2007

SENATE BILL 156 (Chapter 131) – <u>Insurers – Third Party Claimants – Notice of Payment to Claimant's Attorney</u>

- Requires an insurer, at the time it makes payment to a third party claimant in the amount of $2,000 or more in settlement of a bodily injury claim, to provide written notice to the third party claimant of the payment if:

  (1) the claimant is an individual; and

  (2) the payment is delivered to the claimant's attorney by check, draft, or other means.

- Requires that the notice of payment be sent by regular mail to the claimant at the last known address of the claimant no more than 5 working days after payment is delivered to claimant's attorney.

- Specifies that failure by the insurer to send the required notice does not create a cause of action or a defense to a cause of action based on the failure to send the required notice.

Effective Date: October 1, 2007

SENATE BILL 588 (Chapter 338) – <u>Insurance – Binders or Policies – Personal Insurance</u>

- Extends the provisions of § 12-106 of the Insurance Article (which provides a 45 day underwriting period to binders or policies, other than renewal policies) to all types of personal insurance as well as commercial property and commercial liability insurance.

- Provides that a notice of cancellation of the binder or policy during the 45 day underwriting period for nonpayment of premium shall:

  (1) be in writing;

  (2) have an effective date of not less than 10 days after mailing;

  (3) state the insurer's intent to cancel for nonpayment of premium; and

(4) be sent by certificate of mail.

Effective Date: ***October 1, 2007*** *(Applies to all binders or policies of personal insurance issued or delivered on or after October 1, 2007)*

SENATE BILL 765 (Chapter 575) – Workers' Compensation Insurance – Notice – Premiums

- Applies the notice provisions of § 27-608 of the Insurance Article to policies of workers' compensation insurance.

Effective Date: ***May 17, 2007***

SENATE BILL 790 (Chapter 576) – Homeowner's Insurance – Insurance Producers – Notice of Coverage for Flood Loss – Statement of Additional Optional Coverage

- Repeals the application of §§ 19-206 and 19-207 to insurance producers.
- Retains the requirement that the written notices required by those sections must be provided by the insurer.
- Provides that a statement provided under § 19-207, a listing of additional optional coverages available, does not create a private right of action.

Effective Date: ***October 1, 2007*** *(Applies to personal lines homeowner's insurance policies and contracts issued, delivered, or renewed in the State on or after October 1, 2007)*

OTHER

HOUSE BILL 1027 (Chapter 21) / SENATE BILL 220 (Chapter 20) – Real Property – Release of Mortgage, Deed of Trust, or Lien Instrument

- Permits a mortgage, security instrument, or deed of trust to be released validly by any procedure enumerated in §§ 3-105 or 3-105.2 of the Real Property Article.
- Specifies that when the debt secured by a mortgage, deed of trust, or lien instrument is paid fully or satisfied by a settlement agent licensed by the Maryland Insurance Administration as a title insurance producer under Title 10, Subtitle 1 of the Insurance Article, a title insurer, or a lawyer admitted to the Maryland Bar, and the party satisfied fails to provide a release suitable for recording, the settlement

agent, title insurer, or lawyer may prepare and record a statutory release affidavit that:

(1) may be received by the clerk and indexed and recorded as any other instrument in the nature of a release or certificate of satisfaction; and

(2) has the same effect as a release of the property for which the mortgage, deed of trust, or lien instrument is the security, as if a release were executed by the mortgagee, named trustees, or secured party.

- Specifies requirements that must be met by the person filing the statutory release prior to the filing of the statutory release.

- Specifies the content of the statutory release and information that must accompany the statutory release.

Effective Date: July 1, 2007

HOUSE BILL 1241 (Chapter 55) / SENATE BILL 875 (Chapter 54) – <u>Surplus Lines Insurance – Date of Filing Affidavit</u>

- Alters the date on which an affidavit filed with the Commissioner by a surplus lines carrier must be filed to on or before the 45th day after the last day of the calendar quarter in which the surplus lines insurance was placed.

Effective Date: October 1, 2007

HOUSE BILL 1409 (Chapter 651) – <u>Insurance – Fraud – Intentional Motor Vehicle Accidents, Creation of Documentation of Motor Vehicle Accidents, and Reports</u>

- Makes it a fraudulent insurance act for a person, with the purpose of submitting a claim under a policy of motor vehicle insurance, to organize, plan, or knowingly participate in:

(1) an intentional motor vehicle accident; or

(2) a scheme to create documentation of a motor vehicle accident that did not occur.

- Specifies the penalty for a violation of § 27-407.1 of the Insurance Article.

- Specifies who may have access to a motor vehicle accident report during the 60 days following a motor vehicle accident.

- Specifies the penalty to be imposed upon a person who obtains a report in violation of § 20-110 of the Transportation Article.

- Specifies the penalty to be imposed upon an officer of a law enforcement agency who knowingly discloses a report to a person not entitled to access the report under § 20-110 of the Transportation Article.

Effective Date: October 1, 2007

HOUSE BILL 1425 (Chapter 109) – <u>Insurance Producers – Use of Trade Name</u>

- Prohibits the holder of a license from using any name other than the name in which the license is issued or a trade name filed with the Commissioner to engage in any activity for which a license is required, including the execution of any document related to marketing, negotiation, selling, or issuance of insurance.

- Requires a licensee to file with the Commissioner by any means acceptable to the Commissioner a change in trade name within 30 days of the change.

- Specifies that, if a licensee fails to timely file with the Commissioner a change in trade name, the licensee is in violation of § 10–126(a)(1) of the Insurance Article.

Effective Date: October 1, 2007

HOUSE BILL 1432 (Chapter 110) – <u>Insurance – Analyses and Examination Reports – Use and Sharing of Documents, Materials, and Information</u>

- Whenever the Commissioner considers it advisable, the Commissioner shall conduct an analysis or examine the affairs, transactions, accounts, records, assets, and financial condition of each entity enumerated under § 1-205(b) of the Insurance Article.

- Specifies that a document, material, or information that is subject to § 2-205(g) of the Insurance Article:

  (1) is confidential and privileged;

  (2) is not subject to Title 10, Subtitle 6 of the State Government Article;

  (3) is not subject to subpoena; and

  (4) is not subject to discovery or admissible in evidence in any private civil action.

- Permits the Commissioner to use any document, material, or information that is subject to § 2-205(g) of the Insurance Article to further any regulatory or legal action brought as part of the duties of the Commissioner.

- Prohibits the Commissioner and any person that receives a document, material, or information that is subject to § 2-205(g) of the Insurance Article while acting under the authority of the Commissioner from being allowed or required to testify in any private civil action concerning the document, material, or information.

- Permits the Commissioner to share a document, material, or information, including a document, material, or information that is confidential and privileged under § 2-205(g) of the Insurance Article with specified regulatory agencies, the National Association of Insurance Commissioners and specified law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or information.

- Permits the Commissioner to receive a document, material, or information, including a document, material, or information that is confidential and privileged, from specified regulatory agencies, the National Association of Insurance Commissioners and specified law enforcement authorities.

- Requires the Commissioner to maintain as confidential and privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

- Permits the Commissioner to enter into agreements governing the sharing and use of information consistent with § 2-205(h) of the Insurance Article.

- Specifies that there is no waiver of any applicable privilege or claim of confidentiality with regard to a document, material, or information as a result of:

  (1) disclosure of the document, material, or information to the Commissioner under § 2-205(h) of the Insurance Article; or

  (2) sharing of the document, material, or information by the Commissioner under § 2-205(h)(1) of the Insurance Article.

  Effective Date: October 1, 2007

SENATE BILL 389 (Chapter 150) – <u>Civil Actions – Liability of Insurer – Failure to Act in Good Faith</u>

- Creates new Subtitle 17 “Liability of Insurers” in Title 3 of the Courts and Judicial Proceedings Article which applies only to first-party claims under property and casualty insurance policies issued, sold, or delivered in the State.

- Prohibits a party from filing an action under Title 3, Subtitle 17 of the Courts and Judicial Proceedings Article before the date of a final decision under § 27-1001 of the Insurance Article except for an action:

  (1) within the small claim jurisdiction of the district court under § 4-405 of the Courts and Judicial Proceedings Article;

  (2) where the insured and the insurer agree to waive the requirement of a final decision under § 27-1001 of the Insurance Article; or

  (3) under a commercial insurance policy on a claim with respect to which the applicable limit of liability exceeds $1,000,000.

- Specifies that § 3-1701 of the Courts and Judicial Proceedings Article only applies in a civil action:

  (1) to determine the coverage that exists under the insurer's insurance policy or to determine the extent to which the insured is entitled to receive payment from the insurer for a covered loss;

  (2) that alleges that the insurer failed to act in good faith; and

  (3) that seeks, in addition to the actual damages under the policy, to recover expenses and litigation costs, and interest on those expenses or costs, under subsection (e) of § 3-1701 of the Courts and Judicial Proceedings Article.

- Specifies the damages, expenses, costs and interests that the insured may recover from the insurer if the trier of fact in the action finds in favor of the insured AND finds that the insurer failed to act in good faith.

- Prohibits an insurer from being found to have failed to act in good faith solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer.

- Limits the amount of attorneys fees recoverable from an insurer which is found to have failed to have acted in good faith to 1/3 of the amount of the actual damages recovered.

- Requires the clerk of the court to file a copy of the verdict or any other final disposition of an action under § 3-1701 of the Courts and Judicial Proceedings Article with the Maryland Insurance Administration.

- Makes clear that the filing of a complaint with the Maryland Insurance Administration in accordance with § 27-1001 of the Insurance Article will toll the statute of limitations.

- Alters the provisions of § 27-303 of the Insurance Article to make it an unfair claims settlement practice for an insurer to fail to act in good faith, as defined under § 27-1001 of the Insurance Article, in settling a first-party claim under a policy of property and casualty insurance.

- Alters the provisions of § 27-304 of the Insurance Article to make it an unfair claim settlement practice and a violation for an insurer, when committed with the frequency to indicate a general business practice, to fail to act in good faith, as defined under § 27-1001 of the Insurance Article, in settling a first-party claim under a policy of property and casualty insurance.

- Permits the Commissioner to impose a penalty not exceeding $125,000 for each violation of § 27-303(9) of the Insurance Article or a regulation adopted under § 27-303(9) of the Insurance Article.

- Specifies the type of restitution the Commissioner may order for a violation of § 27-303(9) of the Insurance Article to include:

  (1) actual damages not to exceed the applicable policy limits;

  (2) expenses and litigation costs, including reasonable attorneys fees, not to exceed 1/3 of the actual damages recovered; and

  (3) interest on all actual damages, expenses and litigation costs at the legal rate from the date on which the insured's claim would have been paid if the insurer had acted in good faith.

- Creates a new Subtitle 10 of Title 27 of the Insurance Article "Property and Casualty Insurance – First-Party Claims."

- Creates a process for the filing of a complaint with the Maryland Insurance Administration seeking first-party benefits under a policy of property and casualty insurance and alleging a cause of action under § 3-1701 of the Courts and Judicial Proceedings Article.

- Specifies the timeframes, requirements and exchanges of information that are to be made by the parties and the Maryland Insurance Administration.

- Provides for a 90 day determination by the Maryland Insurance Administration following the filing of a complaint alleging a cause of action under § 3-1701 of the Courts and Judicial Proceedings Article. Said determination shall:

  (1) determine whether the insurer is obligated to provide coverage under the applicable policy;

  (2) the amount the insured is entitled to receive from the insurer under the applicable policy;

(3) whether the insurer breached its obligation to cover and pay the underlying first party claim;

(4) whether the insurer that breached that obligation failed to act in good faith; and

(5) the amount of damages, expenses, litigation costs and interest that may be owed to the first-party claimant.

- Specifies that the failure of the Maryland Insurance Administration to issue a determination within 90 days after the filing of the complaint shall be considered to be a determination that the insurer did not breach any obligation to the insured.

- Specifies that either party to the complaint may request a hearing on the determination within 30 days after the date of service of said decision.

- Sets forth the manner in which hearings requested under Subtitle 10 of the Insurance Article are to be processed. All appeals are to be heard de novo.

- Requires the Maryland Insurance Administration, on or before January 1 of each year beginning in 2009, to report to the General Assembly on the following for the prior fiscal year:

  (1) the number and types of complaints under § 27-1001 of the Insurance Article or § 3-1701 of the Courts and Judicial Proceedings Article from insureds regarding first-party insurance claims under property and casualty insurance policies;

  (2) the administrative and judicial dispositions of these complaints;

  (3) the number and types of regulatory enforcement actions instituted by the Administration for unfair claim settlement practices under § 27-303(9) or § 24-304(18) of the Insurance Article; and

  (4) the administrative and judicial dispositions of the regulatory enforcement actions for unfair claim settlement practices.

- Specifies that the provision of the bill providing for administrative penalties and license sanctions that may be imposed by the Maryland Insurance Commissioner apply only to an act or omission occurring on or after October 1, 2007.

Effective Date: October 1, 2007