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### BULLETIN 08-18

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

**Re: Summary of 2008 Insurance Legislation Signed into Law by Governor Martin O'Malley**

**Date: August 2008**

This summary is meant to place insurers, non-profit health service plans, health maintenance organizations, dental plan organizations, pharmacy benefits managers, and producers (hereinafter "regulated entities") authorized to do business in Maryland on notice of certain laws passed in the 2008 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration (MIA). ***The attached synopsis is intended only as notice of the passage of the legislation and is not a representation of the MIA's interpretation of the legislation, nor is it a representation of how the MIA may choose to enforce these new provisions.*** All regulated entities should refer to the 2008 Chapter Laws of Maryland for the complete text of these recently enacted laws. Regulated entities are advised that other bills passed by the General Assembly and not listed on the 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 2008 legislative session by accessing the Maryland Legislative Information System at <http://mlis.state.md.us> on the internet or by contacting the Department of Legislative Services at 410-946-5400. You should refer to the House or Senate Bill number when searching for a law on the "mlis" web site. You can also obtain a copy of "*The 90 Day Report -- A Review of the 2008 Legislative Session*" on the internet or from Library and Information Services, Office of Policy Analysis, Department of Legislative Services.

For additional information concerning the Maryland Insurance Administration's Summary of 2008 Insurance Legislation, please contact Kimberly Y. Robinson, Esq., Director of Government Relations, at 410-468-2202.

## **2008 INSURANCE LEGISLATION**

### **LIFE AND HEALTH**

#### **HOUSE BILL 29 (Chapter 632) / SENATE BILL 918 (Chapter 631) – Long-Term Care Insurance – Prohibited Acts – Genetic Tests, Genetic Information, or Genetic Services**

- Prohibits a carrier that provides long-term care insurance or its insurance producer from:
  - (1) requesting or requiring a genetic test to:
    - (a) deny or limit the amount, extent, or kind of long-term care insurance coverage available to an individual; or
    - (b) charge a different rate for the same long-term care insurance coverage; or
  - (2) using a genetic test, the results of a genetic test, genetic information, or a request for genetic services to:
    - (a) deny or limit the amount, extent, or kind of long-term care insurance coverage available to an individual; or
    - (b) charge a different rate for the same long-term care insurance.
- If the use is based on sound actuarial principles, the results of a genetic test or genetic information may be used to:
  - (1) deny or limit the amount, extent, or kind of long-term care insurance coverage made available to an individual; or
  - (2) charge a different rate for the same long-term care insurance.

***Effective Date: October 1, 2008***

#### **HOUSE BILL 238 (Chapter 259) – Maryland Health Insurance Plan – Status, Operation, and Regulation**

- Makes the Maryland Health Insurance Plan (the Plan) an independent unit of State Government.
- Specifies that the operations of the Plan are subject to the provisions of Title 14, Subtitle 5 of the Insurance Article whether the operations are performed directly by the Plan itself or through an entity contracted with the Plan and requires the Plan to ensure that any entity contracted with the Plan complies with the provisions of Title 14, Subtitle 5 of the Insurance Article when performing services that are subject to Title 14, Subtitle 5 of the Insurance Article on behalf of the Plan.

- Modifies the composition of the Plan's Board of Directors by removing the Insurance Commissioner, and adding to the Board the Secretary of the Department of Health and Mental Hygiene or the designee of the Secretary of Health and Mental Hygiene and a representative appointed by the Governor to represent hospitals in the State.
- Permits the Executive Director of the Maryland Health Care Commission, Executive Director of the Health Services Cost Review Commission and Secretary of Budget and Management to appoint a designee to serve on the Board.
- Permits the Executive Director to employ a staff for the Plan in accordance with the State budget and to determine the appropriate job classifications and grades for all staff, in consultation with the Department of Budget and Management.
- Specifies that staff for the Plan are in the Executive Service, Management Service, or are Special Appointments in the State Personnel Management System.
- Requires the Board to develop, file with the Insurance Commissioner and provide at no charge, on request of the member, a master plan document that sets forth in detail all of the terms and conditions of the standard benefit package.
- Specifies that the Board shall develop a certificate of coverage that describes the essential features of the Plan and the standard benefit package, the content of the certificate of coverage and the distribution of the certificate of coverage to members.
- Specifies the process by which the Board may make a change to the standard benefit package and the timing for which a change may be effective.
- On or before September 1 of each year, the Board shall report to the House Health and Government Operations Committee and the Senate Finance Committee on the current standard benefit package offered by the Plan and any changes to the standard benefit package implemented during the immediately preceding fiscal year.
- Specifies that if there is a conflict between a provision of the master plan document and a provision of the certificate of coverage, the provision that is most beneficial to the member shall control.
- Requires that the contract between the Board and the administrator shall require the administrator to comply with the provisions of Title 14, Subtitle 5 of the Insurance Article to which the Plan is subject.
- Specifies that the Insurance Commissioner shall regulate the Plan and identifies the provisions of the Insurance Article with which the Plan shall comply.
- Prohibits the Insurance Commissioner from imposing a fine or administrative penalty on the Plan.
- Permits the Commissioner to require the Plan to make restitution to each claimant who has suffered actual economic damages because of the violation.
- Requires:

- (1) the Insurance Commissioner to provide a copy of an adopted examination report or the results of any review conducted under Title 14, Subtitle 5 of the Insurance Article to the Board and make recommendations for corrective action to be taken by the Board; and
  - (2) that based on the Insurance Commissioner's recommendations the Board shall determine the steps necessary to implement corrective action to comply with the provisions of Title 14, Subtitle 5 of the Insurance Article, including whether to exercise any remedies available to the Board under the contract between the Board and the Plan administrator.
- Requires that during fiscal year 2009, the Maryland Insurance Administration shall provide fiscal and personnel services to the Maryland Health Insurance Plan at no charge.

***Effective Date: October 1, 2008***

**HOUSE BILL 272 (Chapter 264) – Medical Stop-Loss Insurance**

- Clarifies that Title 3, Subtitle 3 of the Insurance Article does not apply to medical stop-loss insurance, as defined in § 15-129 of the Insurance Article.
- Updates the definition under § 15-129 of the Insurance Article from “stop-loss insurance” to “medical stop-loss insurance.”
- Clarifies the applicability of § 15-129 of the Insurance Article.
- Clarifies that medical stop-loss insurance may only be sold, issued, or delivered in the State by a carrier that holds a certificate of authority issued by the Insurance Commissioner that authorizes the carrier to engage in the business of health insurance or to act as a nonprofit health service plan.

***Effective Date: June 1, 2008***

**HOUSE BILL 289 (Chapter 265) – Task Force on Health Care Access and Reimbursement – Extension**

- Extends the termination date and the date on which the Task Force on Health Care Access and Reimbursement is required to submit its final report and recommendations to December 1, 2008.

***Effective Date: June 1, 2008***

**HOUSE BILL 395 (Chapter 70) – Health Insurance Carriers – Financial Reporting**

- Removes the requirement that a managed care organization file, as part of its annual report to the Insurance Commissioner, a consolidated financial statement.

- Requires that on or before March 1 of each year, unless, for good cause shown, the Insurance Commissioner extends the time for a reasonable period, each managed care organization shall file with the Insurance Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.
- Specifies that at any time, the Insurance Commissioner may require a managed care organization to file an interim statement containing the information that the Insurance Commissioner considers necessary.
- Requires that the annual and any interim reports shall be filed in a form required by the Insurance Commissioner.
- Requires that on or before June 1 of each year, each managed care organization shall file with the Insurance Commissioner an audited financial report for the preceding calendar year that is filed in a form required by the Insurance Commissioner and certified by an audit of an independent certified public accountant.
- Specifies that each financial report filed under §15-605 of the Insurance Article is a public record.

**Effective Date: October 1, 2008**

**HOUSE BILL 462 (Chapter 76) – Health Insurance – Small Group Market – Self-Employed Individuals – Sunset Extension**

- Continues the exclusion of self-employed individuals from Maryland's small group market by altering the sunset date of Chapter 347 of the Acts of 2005, as amended by Chapter 59 of the Acts of 2007, from September 30, 2008 to September 30, 2011.

**Effective Date: July 1, 2008**

**HOUSE BILL 578 (Chapter 510) – Health Insurance – Coverage for Amino Acid-Based Elemental Formula**

- Requires that insurers, nonprofit health service plans and health maintenance organizations, under the family member coverage, provide coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:
  - (1) Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
  - (2) severe food protein induced enterocolitis syndrome;
  - (3) eosinophilic disorders, as evidenced by the results of a biopsy; and
  - (4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

- Specifies that the coverage required by § 15-843 of the Insurance Article is required if the ordering physician has issued a written order stating that the amino acid-based elemental formula is medically necessary for the treatment of a disease or disorder listed in § 15-843(b)(1) of the Insurance Article.
- Specifies that in accordance with subtitle 10A of Title 15 of the Insurance Article, a private review agent, acting on behalf of an insurer, nonprofit health service plan, or health maintenance organization, may review the ordering physician's determination of the medical necessity of the amino acid-based elemental formula for the treatment of a disease or disorder listed in § 15-843(b)(1) of the Insurance Article.
- Specifies that this law apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2008.

**Effective Date: October 1, 2008**

**HOUSE BILL 815 (Chapter 673) – Health Insurance – Reimbursement of Health Care Practitioners – Information Provided by Carriers**

- Requires insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations to provide in a schedule of applicable fees the fifty most common services billed by a health care practitioner in that specialty:
  - (1) in writing at the time of contract execution;
  - (2) in writing or electronically 30 days prior to a change; and
  - (3) in writing or electronically upon request of the health care practitioner.
- Requires a carrier to make the pharmaceutical formulary that the carrier uses available to a health care practitioner electronically.
- Specifies that on written request of a health care practitioner, a carrier shall provide the information required under § 15-113(d)(1) and (3) of the Insurance Article in writing.

**Effective Date: October 1, 2008**

**HOUSE BILL 818 (Chapter 448) / SENATE BILL 744 (Chapter 447) – Task Force on Health Care Access and Reimbursement – Additional Duties**

- Requires the Task Force on Health Care Access and Reimbursement to develop recommendations regarding:
  - (1) whether there is a need to provide incentives for physicians and other health care providers to be available to provide care on evenings and on weekends; and
  - (2) the ability of primary care physicians to be reimbursed for mental health services performed within their scope of practice.

**Effective Date: June 1, 2008**

**HOUSE BILL 872 (Chapter 627) / SENATE BILL 852 (Chapter 626) – Health Insurance – Public-Private Health Care Programs**

- Creates Title 14, Subtitle 7 “Public-Private Health Care Programs” within the Insurance Article, which:
  - (1) specifies the purpose of the subtitle;
  - (2) specifies the requirements for certification as a public-private health care program;
  - (3) specifies when the Insurance Commissioner may deny or refuse to renew, suspend or revoke a certification as a public-private health care program;
  - (4) requires all forms, agreements, advertising, or other documents provided by a certified nonprofit corporation to participants to be truthful and not misleading in fact or by implication and made available to the Insurance Commissioner on request;
  - (5) specifies the manner in which the Insurance Commissioner may enforce Title 14, Subtitle 7 of the Insurance Article, and
  - (6) permits the Insurance Commissioner to adopt regulations to carry out the provisions of Title 14, Subtitle 7 of the Insurance Article.
- Requires that, on or before December 31, 2010, the Maryland Insurance Administration shall report to the Senate Finance Committee and the House Health and Government Operations Committee on the Insurance Administration’s recommendations for the continuation of public-private health care programs in the State.

***Effective Date: June 1, 2008 – May 31, 2013***

**HOUSE BILL 1219 (Chapter 688) – Health Insurance – Health Care Provider Panels – Provider Contracts**

- Repeals current § 15-112(l) of the Insurance Article and creates new § 15-112.2 of the Insurance Article.
- Prohibits a provider contract from containing a provision that requires a provider, as a condition of participating in a non-HMO provider panel, to participate in an HMO provider panel or dental provider panel.
- Permits a provider contract to include a provision that requires a provider, as a condition of participating in a non-HMO provider panel, an HMO provider panel, or a dental provider panel, to participate in a managed care organization.
- Requires that, for an HMO provider panel or a non-HMO provider panel, each provider contract shall disclose the carriers comprising each provider panel.

- If a provider contract includes more than one schedule of applicable fees, prohibits the provider contract from containing a provision that requires a provider as a condition of participation to accept each schedule of applicable fees included in the provider contract.
- If a provider rejects a schedule of applicable fees, prohibits the provider contract from requiring the provider to treat the enrollees of the carriers that reimburse the provider in accordance with any of the rejected schedules of applicable fees.
- Permits a provider contract to include a provision that requires a provider, as a condition of participation, to accept each schedule of applicable fees for a carrier that is not affiliated through common ownership with the entity arranging the provider panel.
- If a provider elects to terminate participation on a provider panel, requires the provider to:
  - (1) notify the carrier at least 90 days before the date of termination; and
  - (2) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services before the notice of termination.
- Applies to all provider contracts issued or renewed in the State on or after October 1, 2009, or, for provider contracts in effect in the State on October 1, 2009, but not subject to renewal before October 1, 2010, no later than October 1, 2010.

**Effective Date: October 1, 2009**

**HOUSE BILL 1391 (Chapter 692) – Kids First Act**

- Alters the definition of “creditable coverage” under § 15-1301 of the Insurance Article to include Title XXI of the Social Security Act.
- Specifies certain requirements on the Office of the Comptroller and the Department of Health and Mental Hygiene designed to raise awareness of and enrollment in the Maryland Medical Assistance Program and the Maryland Children’s Health Insurance Program.
- Requires the Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Administration and the Maryland Health Care Commission:
  - (1) study and make recommendations for improving the processes for determining eligibility for the Maryland Medical Assistance Program and the Maryland Children’s Health Program, including the feasibility of facilitating outreach or auto-enrollment through linkages with other electronic data sources; and
  - (2) (a) study and make recommendations for increasing the availability and affordability of health care coverage for children with family income that exceeds 300% of the applicable poverty income level; and
    - (b) include as options in the study and recommendations:



1. buying into the Maryland Children's Health Program;
  2. developing a State-sponsored health care coverage program with fewer mandates than the Maryland Children's Health Program; and
  3. establishing a health benefit plan with child-appropriate benefits.
- Requires that on or before January 1, 2009, the Department of Health and Mental Hygiene report on its studies and recommendations to the Governor and the General Assembly.
  - Provides that, notwithstanding any other provision of law, for fiscal years 2010 and 2011, up to \$300,000 each year shall be transferred from the Maryland Health Care Provider Rate Stabilization Fund established under Title 19, Subtitle 8 of the Insurance Article to the Office of the Comptroller to pay *only* for mailings of applications and enrollment instructions for the Maryland Medical Assistance Program and the Maryland Children's Health Program, in accordance with § 10-211.1 of the Tax - General Article, as enacted by House Bill 1391.

**Effective Date: July 1, 2008 - June 30, 2011**

**HOUSE BILL 1492 (Chapter 558) / SENATE BILL 906 (Chapter 557) – Senior Prescription Drug Assistance Program – Subsidy for Medicare Part D Coverage and Sunset Extension**

- Requires that beginning January 1, 2009, and each January 1 thereafter, if a corporation subject to § 14-106.2 of the Insurance Article has a surplus that exceeds 800% of the consolidated risk-based capital requirements applicable to the corporation in the immediately preceding calendar year, the corporation shall transfer \$4,000,000 to the separate account for the Senior Prescription Drug Assistance Program within the Maryland Health Insurance Plan fund established under § 14-504 of the Insurance Article.
- Specifies that a corporation is not required to make the transfer under § 14-106.2(b) of the Insurance Article if:
  - (1) the surplus of the corporation does not exceed 800% of the consolidated risk-based capital requirements applicable to the corporation in the immediately preceding calendar year; or
  - (2) the federal government eliminates the coverage gap in the Medicare Part D prescription drug benefit.
- Requires the Senior Prescription Drug Assistance Program to annually provide an additional subsidy up to the full amount of the Medicare Part D coverage gap, subject to the availability of funds provided under § 14-106.2 of the Insurance Article and any other funds available for this purpose.
- Requires a nonprofit health service plan to deposit in the Fund under § 14–504 of the Insurance Article the amount required under § 14-106.2 of the Insurance Article to be used for the purpose of subsidizing the Medicare Part D coverage gap.

- Extends the Senior Prescription Drug Assistance Program established under Title 14, Subtitle 5, Part II, as amended, until December 31, 2010.

**Effective Date: October 1, 2008**

**HOUSE BILL 1587 (Chapter 245) / SENATE BILL 974 (Chapter 244) – Health Services Cost Review Commission – Averted Uncompensated Care – Assessment**

- Requires that each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to:
  - (1) reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly; and
  - (2) operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.
- Specifies that funds generated from the assessment under § 19-214(d) of the Health - General Article may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008 and provide funding for the operation and administration of the Maryland Health Insurance Plan.
- Requires that on or before January 1, 2009, and annually thereafter, the Commission shall report to the Governor and the General Assembly on:
  - (1) the implementation of the Small Employer Health Benefit Plan Premium Subsidy Program; and
  - (2) the uncompensated care savings derived from the program and the methodology used by the Commission to track the uncompensated care savings.

**Effective Date: July 1, 2008**

**SENATE BILL 192 (Chapter 25) – Maryland Health Insurance Plan – Application of Insurance Fraud Law**

- Expands § 27-402 of the Insurance Article to include the Maryland Health Insurance Plan.

**Effective Date: October 1, 2008**

**SENATE BILL 595 (Chapter 598) – Health Insurance – Carrier Credentialing – Reimbursement of Providers of Health Care Services**

- Requires a carrier to reimburse a group practice on the carrier's provider panel at the participating provider rate for covered services provided by a provider who is not a participating provider if:

- (1) the provider is employed by or a member of the group practice;
  - (2) the provider has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information;
  - (3) the provider has a valid license issued by a health occupations board to practice in the State; and
  - (4) the provider:
    - (a) is currently credentialed by an accredited hospital in the State; or
    - (b) has professional liability insurance.
- Requires a carrier to reimburse a group practice on the carrier's provider panel from the date the notice required under § 15-112(d)(3)(i)1 of the Insurance Article is sent to the provider until the date the notice required under § 15-112(d)(3)(iii)2 of the Insurance Article is sent to the provider.
  - Specifies that a carrier that sends written notice of rejection of a provider for credentialing under § 15-112(d)(3)(iii)2 of the Insurance Article shall reimburse the provider as a nonparticipating provider for covered services provided on or after the date the notice is sent.
  - Specifies that a health maintenance organization may not deny payment to a provider under § 15-112(q) (as enacted by SB 595) of the Insurance Article solely because the provider was not a participating provider at the time the services were provided to an enrollee.
  - Specifies that a provider who is not a participating provider of a carrier and whose group practice is eligible for reimbursement under § 15-112(q)(1) (as enacted by SB 595) of the Insurance Article may not hold an enrollee of the carrier liable for the cost of any covered services provided to the enrollee during the time period described in § 15-112(q)(2) (as enacted by SB 595) of the Insurance Article, except for any deductible, copayment, or coinsurance amount owed by the enrollee to the group practice or provider under the terms of the enrollee's contract or certificate.
  - Requires that a group practice disclose in writing to an enrollee at the time services are provided that:
    - (1) the treating provider is not a participating provider;
    - (2) the treating provider has applied to become a participating provider;
    - (3) the carrier has not completed its assessment of the qualifications of the treating provider to provide services as a participating provider; and
    - (4) any covered services received must be reimbursed by the carrier at the participating provider rate.

**Effective Date: October 1, 2008**

**PHARMACY BENEFITS MANAGERS LEGISLATION (Life and Health)**

**(Note: The same section numbers are used in each of these bills. When the law is published, the numbering will be corrected to alleviate the duplication.)**

**HOUSE BILL 120 (Chapter 206) / SENATE BILL 724 (Chapter 205) – Pharmacy Benefits Managers – Disclosures**

- Specifies that §§ 15-1603 through 15-1606 of the Insurance Article do not apply to a pharmacy benefits manager when providing pharmacy benefits management services to a purchaser that is affiliated with the pharmacy benefits manager through common ownership within an insurance holding company.
- Requires that a pharmacy benefits manager make certain disclosures before entering into a contract with a purchaser.
- Requires that a pharmacy benefits manager offer to provide certain information to a purchaser and provide that information to the purchaser before entering into a contract, if requested.
- Specifies that, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information described in § 15-1603(a)(2) of the Insurance Article is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.
- Requires that, if a purchaser has a rebate sharing contract, a pharmacy benefits manager shall offer to provide the purchaser a report containing certain pertinent information for each fiscal quarter and each fiscal year and specifies what information should be offered if the exact amounts are not available at the time of the report.
- Specifies that, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information in § 15-1604(a) and (b) of the Insurance Article is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.
- Specifies that Title 15, Subtitle 16 of the Insurance Article does not diminish the authority of the Office of the Attorney General or the Commissioner to obtain information relating to a pharmacy benefits manager and use the information in any proceeding.

***Effective Date: October 1, 2008***

**HOUSE BILL 257 (Chapter 262) – Pharmacy Benefits Managers – Contracts with Pharmacies and Pharmacists**

- Specifies information that shall be disclosed by a pharmacy benefits manager at the time of entering into a contract with a pharmacy or a pharmacist, and at least 30 working days before any contract change.

- Specifies the procedure permitted by law for an audit of a pharmacy or pharmacist conducted by a pharmacy benefits manager for reasons other than probable or potential fraud or willful misrepresentation by a pharmacy or pharmacist.
- Prohibits a pharmacy benefits manager from using the accounting practice of extrapolation to calculate overpayments or underpayments.
- Requires the recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager to be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist.
- Requires a pharmacy benefits manager to establish an internal appeals process under which a pharmacy or pharmacist may appeal any disputed claim in a preliminary audit report.
- Requires a pharmacy benefits manager to establish a reasonable internal review process for a pharmacy to request the review of a failure to pay the contractual reimbursement amount of a submitted claim.
- Requires that, on request of the Commissioner or the Commissioner's designee, a pharmacy benefits manager shall provide a copy of its audit procedures or internal appeals process.
- Specifies that the provisions of House Bill 257 apply to contracts entered into or renewed between a pharmacist or pharmacy and a pharmacy benefits manager on or after January 1, 2009 and to audits conducted by pharmacy benefits managers on or after January 1, 2009.
- Specifies that nothing in this Act shall be construed to limit the applicability of §§ 15–1008, 15–1009(b), 27–303(2), 27–304(4), and 27–304(15) of the Insurance Article to claim denials made by or on behalf of an insurer, nonprofit health service plan, dental plan organization, or health maintenance organization.

***Effective Date: October 1, 2008***

**HOUSE BILL 343 (Chapter 204) / SENATE BILL 723 (Chapter 203) – Pharmacy Benefits Managers – Therapeutic Interchanges**

- Prohibits a pharmacy benefits manager or its agent from requesting a therapeutic interchange unless:
  - (1) the proposed therapeutic interchange is for medical reasons that benefit the beneficiary; or
  - (2) the proposed therapeutic interchange will result in financial savings and benefits to the purchaser or the beneficiary.

- Requires that, before making a therapeutic interchange, a pharmacy benefits manager or its agent obtain authorization from a prescriber or an individual authorized by the prescriber.
- Specifies information to be disclosed to a prescriber during a therapeutic interchange solicitation.
- Prohibits a pharmacy benefits manager or its agent from making a claim that the therapeutic interchange will save the purchaser money unless the claim can be substantiated when soliciting a therapeutic interchange from a prescriber.
- Requires that, if the pharmacy benefits manager or its agent receives payment for making a therapeutic interchange from a pharmaceutical manufacturer or other person, including the pharmacy benefits manager, that is not reflected in cost savings to the purchaser, the existence of the payment shall be communicated to the prescriber at the time of the therapeutic interchange solicitation.
- Specifies the information that, if a therapeutic interchange occurs, the pharmacy benefits manager or its agent must disclose to the beneficiary, orally or in writing, and the information the pharmacy benefits manager or its agent must include with the prescription drug dispensed.
- Requires that a pharmacy benefits manager or its agent shall cancel and reverse a therapeutic interchange on written or verbal instructions from a prescriber, the beneficiary, or the beneficiary's representative.
- Specifies actions a pharmacy benefits manager must take if a therapeutic interchange is reversed.
- Requires a pharmacy benefits manager to maintain a toll-free telephone number Monday through Saturday for prescribers, pharmacies, pharmacists, and beneficiaries to request information regarding a therapeutic interchange and specifies the hours during which the number shall be accessible.
- Requires that all disclosures made under § 15-1602 of the Insurance Article shall comply with the privacy standards set forth in state and federal law.
- Requires that a pharmacy benefits manager establish appropriate policies and procedures to implement the requirements of § 15-1602 of the Insurance Article.

**Effective Date: October 1, 2008**

**HOUSE BILL 419 (Chapter 202) / SENATE BILL 722 (Chapter 201) – Pharmacy Benefits Managers – Registration**

- Requires a pharmacy benefits manager to register with the Commissioner as a pharmacy benefits manager before providing pharmacy benefits management services in the State to purchasers.
- Requires an applicant for registration as a pharmacy benefits manager to:

- (1) file with the Commissioner an application on the form that the Commissioner provides; and
- (2) pay to the Commissioner a registration fee set by the Commissioner.
- Specifies the term of a pharmacy benefits manager registration, the requirements for renewal of a registration, and the circumstances under which the Commissioner may deny, suspend, or revoke a registration or refuse to renew a registration.
- Prohibits a pharmacy benefits manager from shipping, mailing, or delivering prescription drugs or devices to a person in the State through a nonresident pharmacy unless the nonresident pharmacy holds a permit issued in accordance with the provisions of § 12-403 of the Health Occupations Article.
- Permits the Commissioner, whenever the Commissioner considers it advisable, to examine the affairs, transactions, accounts, and records of a registered pharmacy benefits manager.
- Requires a pharmacy benefits manager to maintain adequate books and records about each purchaser for which the pharmacy benefits manager provides pharmacy benefits management services:
  - (1) in accordance with prudent standards of record keeping;
  - (2) for the duration of the agreement between the pharmacy benefits manager and the purchaser; and
  - (3) for 3 years after the pharmacy benefits manager ceases to provide pharmacy benefits management services for the purchaser.
- Specifies the action that the Commissioner may take and the applicable process if the Commissioner determines that a pharmacy benefits manager has violated any provision of or any regulation adopted under Title 15, Subtitle 16 of the Insurance Article.
- Provides that a person acting as a pharmacy benefits manager in the State on the effective date of this Act may continue to act as a pharmacy benefits manager in the State without being registered with the Maryland Insurance Commissioner, as required under Title 15, Subtitle 16 of the Insurance Article, if the person:
  - (1) registers with the Commissioner on or before July 1, 2009; and
  - (2) complies with all other applicable provisions of Title 15, Subtitle 16 of the Insurance Article.

***Effective Date: October 1, 2008***

**HOUSE BILL 580 (Chapter 279) – Pharmacy Benefits Managers – Pharmacy and Therapeutic Committees**

- Establishes requirements for a pharmacy and therapeutics committee for a pharmacy benefits manager.

- Requires a pharmacy benefits manager to ensure that its pharmacy and therapeutics committee has:
  - (1) policies and procedures to address potential conflicts of interest that members of the pharmacy and therapeutics committee may have with developers or manufacturers of prescription drugs;
  - (2) a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs;
  - (3) a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs when recommending utilization review requirements, dose restrictions, and step therapy requirements; and
  - (4) a process to enable the pharmacy and therapeutics committee to consider the need to recommend a formulary change to a purchaser in a timely manner but at least annually.
- Permits the Commissioner to consider a pharmacy and therapeutics committee of a pharmacy benefits manager as having met the requirements of § 15-1602(b) and (c) of the Insurance Article if the pharmacy benefits manager has obtained accreditation from an accrediting organization approved by the Commissioner.
- Requires that, on request of a purchaser for which the pharmacy and therapeutics committee makes recommendations, a pharmacy benefits manager shall disclose information about the composition of its pharmacy and therapeutics committee to the purchaser.
- Prohibits a pharmacy benefits manager from requiring a pharmacist to participate on its pharmacy and therapeutics committee.
- Permits the Commissioner to adopt regulations to implement Title 15, Subtitle 16 of the Insurance Article.

***Effective Date: October 1, 2008***

## **PROPERTY AND CASUALTY**

### **HOUSE BILL 405 (Chapter 72) – Homeowner’s Insurance – Loss from Water and Sewer Backup – Offer of Coverage**

- Clarifies that an insurer that issues, sells, or delivers a homeowner’s insurance policy shall offer, in writing, at time of application and renewal, to provide coverage for loss that is caused by or results from water that backs up through sewers or drains and is not caused by the negligence of the insured.
- Specifies that if an application or renewal is made by telephone, the insurer is deemed to be in compliance with § 19-202(a) of the Insurance Article if, within 7 calendar days after



the date of application or renewal, the insurer sends by certificate of mailing the offer to the applicant or insured.

- Specifies that if an application or renewal is made using the internet, the insurer is deemed to be in compliance with § 19-202(a) of the Insurance Article if the insurer provides the offer to the applicant or insured prior to submission of the application or renewal.

**Effective Date: October 1, 2008**

**HOUSE BILL 600 (Chapter 357) / SENATE BILL 61 (Chapter 356) – Commission to Study the Title Insurance Industry in Maryland**

- Creates the Commission to Study the Title Insurance Industry in Maryland (“Commission”).
- Specifies that the membership of the Commission shall consist of:
  - (1) three members of the Senate, including at least one member each from the Senate Finance Committee and Senate Judicial Proceedings Committee, appointed by the President of the Senate;
  - (2) three members of the House, including at least one member each from the House Economic Matters Committee and House Environmental Matters Committee, appointed by the Speaker of the House;
  - (3) the Maryland Insurance Commissioner, or the Commissioner’s designee;
  - (4) the Maryland Attorney General, or the Attorney General’s designee;
  - (5) the Commissioner of Financial Regulation, or the Commissioner’s designee;
  - (6) the Executive Director of the Maryland Real Estate Commission, or the Executive Director’s designee;
  - (7) the chair of the Maryland Affordable Housing Trust, or the chair’s designee;
  - (8) a title insurance producer licensed in Maryland, designated by the Maryland Land Title Association;
  - (9) a representative of a title insurance company domiciled in Maryland, designated by the Maryland Land Title Association;
  - (10) a representative of a national title insurance company doing business in Maryland and other states, designated by the Maryland Coalition of Title Insurers;
  - (11) a mortgage broker licensed in Maryland, designated by the Maryland Association of Mortgage Brokers;

- (12) a mortgage lender affiliated with a bank and doing business in Maryland, designated by the Maryland Mortgage Bankers Association;
  - (13) a representative of the Maryland Bankers Association, designated by the Maryland Bankers Association;
  - (14) a representative of the Maryland State Builders Association, designated by the Maryland State Builders Association;
  - (15) a representative of the Section of Real Property Planning and Zoning of the Maryland State Bar Association, designated by the Maryland State Bar Association;
  - (16) a practicing real estate attorney familiar with title insurance settlements and not licensed as a title insurance producer, designated by the Maryland State Bar Association; and
  - (17) a consumer member appointed by the Governor.
- Specifies that the Commission shall be co-chaired by:
    - (1) one of the members of the Senate, as designated by the President of the Senate; and
    - (2) one of the members of the House of Delegates, as designated by the Speaker of the House.
  - Requires that the Commission shall be jointly staffed by the Department of Labor, Licensing, and Regulation and the Maryland Insurance Administration.
  - Specifies that the purpose of the Commission is to make recommendations for changes to State laws relating to the title insurance industry.
  - Indicates that in order to develop recommendations, the Commission shall:
    - (1) review State laws relating to the title insurance industry;
    - (2) review the mechanisms available to enforce State laws relating to the title insurance industry and the effectiveness of those mechanisms;
    - (3) identify title insurance industry issues that affect consumers in Maryland;
    - (4) examine the rate-setting factors for title insurance premiums;
    - (5) examine how rates and services in a title plant state compare to those in Maryland;
    - (6) identify ways to improve consumer education about the title insurance industry;
    - (7) study whether mechanics' liens on properties scheduled for settlement have an impact on the timeliness of settlements or on title insurance premium rates;

- (8) review the time limits, subsequent to closing, for the issuance of title insurance policies;
  - (9) study affiliated business arrangements among title insurance producers, builders, title insurance companies, realtors, lenders, and other businesses involved with the settlement of real estate transactions to determine the impact of these arrangements on title insurance premium rates; and
  - (10) study any other issue with significant impact on the title insurance industry.
- Requires that the Commission shall report on its findings and recommendations to the Governor and the General Assembly on or before December 15, 2009.

**Effective Date: July 1, 2008 - June 30, 2010**

**HOUSE BILL 750 (Chapter 88) – Insurance – Notice of Cancellation of Binders or Policies – Certificate of Mail**

- Clarifies that cancellations under § 12-106 of the Insurance Article shall be sent by certificate of mail.

**Effective Date: October 1, 2008**

**HOUSE BILL 859 (Chapter 95) – Property and Casualty Insurance Policies – Coverage for Additional Living Expenses**

- Specifies that a policy of homeowner's, fire, farmowner's, or dwelling insurance that provides coverage for additional living expenses incurred by an insured as a result of a covered loss may not be issued, sold, or delivered in the State if the policy contains language that limits coverage for additional living expenses to a period of time that is less than 12 months.
- Specifies that a clause in a policy of homeowner's, fire, farmowner's, or dwelling insurance that purports to limit coverage for additional living expenses incurred by an insured as a result of a covered loss to a period of time that is less than 12 months is void and unenforceable.
- Permits the Insurance Commissioner to require an insurer to provide coverage for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance for up to 24 months, not to exceed any applicable monetary limit for this coverage, if the Insurance Commissioner finds that covered property remains uninhabitable due to delays in repair or replacement caused:
  - (1) by the insurer; or
  - (2) by factors beyond the control of the insured.
- Specifies that nothing in § 19-208 of the Insurance Article shall be construed to:

- (1) prohibit or prevent the enforcement of a monetary limit of liability for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance;
- (2) prohibit an insurer from denying coverage for additional living expenses if the carrier determines that at the time the additional living expenses were incurred the covered property was not unfit to live in; or
- (3) prohibit an insurer from denying coverage for additional living expenses on the grounds that the covered property was unfit to live in at the time that the additional living expenses were incurred because of delays in repair or replacement caused by the insured.

**Effective Date: October 1, 2008**

**HOUSE BILL 1353 (Chapter 540) – Omnibus Coastal Property Insurance Reform Act**

- Prohibits an insurer that issues a policy of homeowner's insurance from adopting an underwriting standard that requires a deductible that exceeds 5% of the "Coverage A – Dwelling Limit" of the policy in the case of a hurricane or other storm, unless:
  - (1) the insurer has filed the underwriting standard for approval by the Commissioner;  
and
  - (2) the Commissioner has approved the underwriting standard in writing.
- Specifies the required timing and content of a filing under § 19-208(a)(1) of the Insurance Article.
- Prohibits an underwriting standard subject to § 19-208(a) of the Insurance Article from taking effect until 60 days after it is filed with the Commissioner and permitting the Commissioner to extend or reduce the time before an underwriting standard filed under § 19-208(a)(1) of the Insurance Article may be implemented under certain circumstances.
- Specifies that, if an insurer has adopted an underwriting standard that requires a deductible equal to a percentage of the "Coverage A – Dwelling Limit" of the policy in the case of a hurricane or other storm, the deductible may only be applicable starting no sooner than the time the National Hurricane Center of the National Weather Service issues a hurricane warning for any part of the State where the insured's home is located and ending no later than 24 hours following the termination of the last hurricane warning issued for any part of the State in which the insured's home is located.
- Requires an insurer that has adopted an underwriting standard that requires a deductible equal to a percentage of the "Coverage A – Dwelling Limit" of the policy limits of the policy in the case of a hurricane or other storm to provide a policyholder with an annual statement that provides an explanation of the manner in which the deductible is applied and to send a copy of the form the company will use to provide the notice to the Commissioner prior to its use.

- Requires, under § 19-209 of the Insurance Article, an insurer to offer at least one actuarially justified premium discount on a policy of homeowner's insurance to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm and that any such loss mitigation efforts are subject to inspection by a contractor licensed by the Department of Labor, Licensing, and Regulation.
- Specifies that an insurer shall be allowed to inspect the improvements that are the basis of a premium discount being sought under § 19-209 of the Insurance Article.
- Specifies that verification of improvements that are the basis of a premium discount under § 19-209 of the Insurance Article rests with the insurer.
- Requires a premium discount offered under § 19-209 of the Insurance Article:
  - (1) comply with the provisions of Title 11 of the Insurance Article; and
  - (2) only be offered for improvements identified by the Commissioner as qualified mitigation actions made to the insured premises that may materially mitigate loss from a hurricane or other storm otherwise covered under the policy.
- Requires an insurer that offers a premium discount under § 19-209 of the Insurance Article to provide a policyholder with an annual statement regarding the availability of the discount and the method of applying for the discount and permits the notice to be sent with the statement required under § 19-205 of the Insurance Article.
- Section 19-210 requires an insurer that uses a catastrophic risk planning model or other model in setting homeowner's insurance rates or refusing to issue or renew homeowner's insurance because of the geographic location of the risk to:
  - (1) file with the Commissioner a description of the specific model used in setting the rate or refusing to issue or renew homeowner's insurance because of the geographic location of the risk; and
  - (2) make arrangements for the vendor of the model to explain to the Commissioner the data used in the model and the manner in which the output is obtained.
- Requires that, if at any time an insurer changes the catastrophic risk planning model or other model upon which it is relying, the insurer shall notify the Commissioner of the change and comply with § 19-210(a)(1) of the Insurance Article.
- Specifies that the information filed under § 19-210(a) of the Insurance Article is proprietary and confidential commercial information under § 10-617(d) of the State Government Article.
- Section 19-211 requires any insurer that seeks to reduce its existing homeowner's insurance policies during a one-year period by 3% or more on a statewide basis, based on the location of the risk, shall be engaging in a material reduction and is required to file with the Commissioner, at least 60 days in advance, a plan for orderly reduction of its book of business.

- Specifies the content of a plan of material reduction and the timing under which the plan may become effective.
- Requires the Commissioner to approve the plan of material reduction if the insurer demonstrates that the material reduction is accomplished in a manner that minimizes market disruption in the areas of material reduction.
- Specifies information that the Commissioner must assess in reviewing a plan of material reduction.
- In the uncodified language of the bill, the Maryland Department of Housing and Community Development is required to review current statewide building codes and develop enhanced building codes for coastal regions of the State that promote disaster-resistant construction in the coastal regions of the State. The Department shall report their findings and recommendations to the Senate Finance Committee and House Economic Matters Committee on or before October 1, 2010. The enhanced building codes shall be provided to the planning boards of the counties in the coastal areas of the State.

***Effective date: October 1, 2008 (with the exception of Section 19-209 dealing with loss mitigation efforts and premium discounts, which is not effective until June 1, 2009)***

**HOUSE BILL 1522 (Chapter 329) – Maryland Health Care Provider Rate Stabilization Fund – Allocations to and Disbursements from the Medical Assistance Program Account**

- Alters the amount and specifies to what account the Commissioner shall allocate funds in fiscal year 2009 through fiscal year 2012 and thereafter.
- Expands the definition of “health care provider” under § 19-807 to include a health care practitioner licensed under Title 4 of the Health Occupations Article.
- Requires the Secretary of the Department of Health and Mental Hygiene to determine health care provider rate increases in consultation with managed care organizations, the Maryland Hospital Association, the Maryland State Medical Society, the American Academy of Pediatrics, Maryland Chapter, the American College of Emergency Room Physicians, Maryland Chapter, the Maryland State Dental Association, and the Maryland Dental Society.
- States that it is the intent of the General Assembly that, until fee-for-service health care provider rates paid by the Medical Assistance Program and managed care organization health care provider rates are at a level of rates paid to similar providers for the same services under the federal Medicare fee schedule, funds in the Medical Assistance Program Account established under Title 19, Subtitle 8 of the Insurance Article should be used only to maintain and increase health care provider rates under the Program and not to otherwise generally support the operations of the Program.

***Effective Date: July 1, 2008***

**HOUSE BILL 1581 (Chapter 117) – Private Passenger Motor Vehicle Insurance, Homeowner’s Insurance, and Personal Insurance – Renewals of Policies – Transfers of Policyholders Between Insurers**

- Specifies that for purposes of § 27-501(q) of the Insurance Article, with respect to private passenger motor vehicle insurance policies and homeowner’s insurance policies, the transfer of a policyholder between admitted insurers within the same insurance holding company system, as defined in § 7-101 of the Insurance Article, is a renewal if:
  - (1) the policyholder’s premium does not increase; and
  - (2) the policyholder does not experience a reduction in coverage.
- Specifies that for purposes of Title 27, Subtitle 6 of the Insurance Article, with respect to policies of personal insurance and private passenger motor vehicle liability insurance, the issuance by an insurer of a new policy to replace an expiring policy issued by that insurer is a renewal.
- Specifies that for purposes of Title 27, Subtitle 6 of the Insurance Article, with respect to policies of personal insurance and private passenger motor vehicle liability insurance, the issuance by an insurer of a new policy to replace an expiring policy issued by another admitted insurer within the same insurance holding company system, as defined in § 7-101 of the Insurance Article, is a renewal if:
  - (1) the policyholder’s premium does not increase; and
  - (2) the policyholder does not experience a reduction in coverage.
- Requires that if a policyholder is being transferred between admitted insurers within the same insurance holding company system, as defined in § 7-101 of the Insurance Article, the notice required under § 27-610(a)(2) of the Insurance Article shall include disclosure of the transfer.

**Effective Date: October 1, 2008**

**SENATE BILL 545 (Chapter 589) – Health Care Funds – Transfers and Disbursements**

- Specifies that in fiscal year 2009, \$83,275,000 of the balance remaining in the Rate Stabilization Account at the end of fiscal year 2008 shall be transferred as follows:
  - (1) \$7,000,000 to the Medical Assistance Program Account, to be used by the Secretary of the Department of Health and Mental Hygiene to increase fee-for-service provider rates to dentists in fiscal year 2009;
  - (2) \$3,000,000 to the Health Care Coverage Fund established under Title 15, Subtitle 7 of the Health - General Article, to be used for allowable expenses in fiscal year 2009; and
  - (3) \$73,275,000 to the Health Care Coverage Fund established under Title 15, Subtitle 7 of the Health - General Article, to be used for allowable expenses in fiscal year 2010 and fiscal year 2011.

- Requires the Legislative Auditor to:
  - (1) conduct a fiscal and compliance audit of the accounts and transactions of the Medical Mutual Liability Insurance Society (“Society”) for each year in which the Society receives a disbursement from the Rate Stabilization Account under § 19-805 of the Insurance Article other than a disbursement made under § 19-805(b)(3) of the Insurance Article; and
  - (2) within one year of the date of an audit report required under § 24-213(a) of the Insurance Article, to conduct a follow-up audit to determine the status of any audit recommendations.
  
- Provides that, notwithstanding § 7-317(g)(1) of the State Finance and Procurement Article or any other provision of law, the Governor may, by budget amendment, transfer up to \$2,000,000 of the funds in the Cigarette Restitution Fund established under § 7-317 of the State Finance and Procurement Article to the Department of Health and Mental Hygiene Program MQ0103 Medical Care Programs Administration, if revenues for fiscal year 2009 attained by the Cigarette Restitution Fund exceed the \$170,780,000 in total net sources of revenue noted in Appendix M of the Governor’s Budget Books.
  
- Provides that, notwithstanding § 9-120 of the State Government Article or any other provision of law, after cumulative distributions for fiscal year 2008 to the General Fund under § 9-120(b)(1)(ii) of the State Government Article total \$497,111,000, \$13,000,000 of the remaining revenue that would otherwise be paid to the General Fund under § 9-120(b)(1)(ii) of the State Government Article shall be distributed to a special fund, to be used only as provided in this Section. The Governor may, by budget amendment, transfer up to \$13,000,000 of the money in the special fund to the Department of Health and Mental Hygiene Program MQ0103 Medical Care Programs Administration.
  
- Provides that, notwithstanding § 19-310.1 of the Health - General Article or any other provision of law, the Department of Health and Mental Hygiene may use \$8,500,000 of General Funds and \$8,500,000 of Federal Funds currently allocated for nursing home reimbursements in the fiscal year 2009 budget to fund an increase in utilization of long-term care services resulting from any changes in the level of care used to determine medical assistance eligibility. On or before November 1, 2008, the Department of Health and Mental Hygiene shall submit a report to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee concerning the changes made in the level of care, the number of additional individuals eligible for care as a result of the changes, and the fiscal implications of the change.

**Effective Date: July 1, 2008**

**SENATE BILL 571 (Chapter 192) – Surety Insurers – Failure to Pay Bail Bond Judgment – Penalties**

- Applies the penalties under § 4-113 of the Insurance Article to a surety insurer that is precluded or removed by a circuit court from the list of surety insurers eligible to post bonds with any circuit court because that surety insurer failed to timely resolve or satisfy one or more bail bond forfeiture judgments.



- Requires that within 14 days after the failure of a surety insurer to resolve or satisfy all bond forfeitures in default by the circuit court's deadline, the court clerk shall notify the Commissioner, in writing, of the name of that surety insurer and each bond forfeiture that was not resolved or satisfied by the court's deadline.

**Effective Date: October 1, 2008**

**SENATE BILL 679 (Chapter 612) – Injured Workers' Insurance Fund – Regulation by the Maryland Insurance Commissioner**

- Makes the Injured Workers Insurance Fund ("IWIF") subject to Title 2, Subtitle 2 (Enforcement) of the Insurance Article and permits the Commissioner to enforce the provisions of the Insurance Article that IWIF is now subject to as set forth in § 10-125 of the Labor and Employment Article.
- In the uncodified language, the Maryland Insurance Administration is required to study the impact of subjecting IWIF to the provisions of law regarding rate making, rating, and rate reviews that are enforced by the Insurance Administration for other property and casualty insurers writing workers' compensation insurance.
- Requires the study to include:
  - (1) an analysis of whether IWIF's current rate making practices produce actuarially sound rates;
  - (2) a determination of the cost impact to IWIF if IWIF were to be required to file its rates through a rating organization; and
  - (3) a comparison of the experience rating plan used by IWIF for small employers as compared to the experience rating plan established by a rating organization for small employers.
- Requires the Insurance Administration to identify other provisions of law relating to consumer protections and financial soundness that are enforced by the Insurance Administration and are applicable to other property and casualty insurers, but are not applicable to IWIF.
- In conducting its study and identification of other provisions of law under subsections (a) and (b) of § 10-125 of the Labor and Employment Article, the Insurance Administration shall seek input, as appropriate, from the Injured Workers' Insurance Fund, the National Council on Compensation Insurance, Inc., the Maryland Association of Counties, the Maryland Municipal League, representatives of small businesses, and any other person that the Insurance Administration considers appropriate.
- The Insurance Administration shall issue its report with its findings and recommendations, in accordance with Section 2-1246 of the State Government Article, to the Senate Finance Committee and House Economic Matters Committee on or before December 1, 2008.

**Effective Date: October 1, 2008**

## **OTHER**

### **HOUSE BILL 277 (Chapter 63) – Maryland Insurance Commissioner – Adoption of Regulations Applicable in an Emergency – Required**

- Requires the Commissioner to adopt regulations that may be applied when:
  - (1) the Governor has declared a state of emergency for the State or an area within the State under § 14-107 of the Public Safety Article; or
  - (2) the President of the United States has issued a major disaster or emergency declaration for the State or an area within the State under the Federal Stafford Act.
- Specifies that the regulations may apply to any person regulated by the Commissioner under the Insurance Article or Title 19, Subtitle 7 of the Health - General Article.
- Specifies the matters which the regulations may address.
- Requires that in order to activate a regulation adopted under § 2-115 of the Insurance Article, the Commissioner shall issue a bulletin specifying:
  - (1) that the regulation is activated;
  - (2) the line or lines of business to which the regulation applies;
  - (3) the geographic areas to which the regulation applies; and
  - (4) the period of time for which the regulation applies.
- Prohibits a regulation activated under § 2-115(c)(1) of the Insurance Article from applying beyond the duration of, or the geographical area included within, the Governor's or President's declaration of a state of emergency or disaster.
- Requires the Commissioner to provide a copy of the bulletin to the emergency contact designated by the person subject to the bulletin and permits the Commissioner to post a copy of the bulletin on the Maryland Insurance Administration's website.

***Effective Date: October 1, 2008***

### **HOUSE BILL 404 (Chapter 271) – Insurance Fraud – Required Disclosure Statements**

- With the exceptions set out below, requires all applications for insurance and all claim forms, regardless of the form of transmission, to carry a fraud statement substantially similar to the following:

“Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

- Specifies that the lack of the required statement does not constitute a defense in any legal proceeding.
- Exempts from the provisions of § 27-805(b)(1) of the Insurance Article:
  - (1) Reinsurance applications or claim forms; or
  - (2) The uniform claims form for reimbursement of hospital services or the uniform claims form for reimbursement of health care practitioners services adopted by the Commissioner under § 15-1003 of the Insurance Article.
- Requires that all insurers subject to the provisions of § 27-805 of the Insurance Article shall comply on or before April 1, 2009.

Comment [w1]:

**Effective Date: October 1, 2008**

**HOUSE BILL 514 (Chapter 453) / SENATE BILL 775 (Chapter 452) – Maryland Medbank Program – Funding**

- Provides that for fiscal year 2009 only, funds remaining from the Senior Prescription Drug Program that have accrued to the account of the Senior Prescription Drug Assistance Program of the Maryland Health Insurance Plan Fund may be transferred and appropriated in the budget bill or by budget amendment to the Department of Health and Mental Hygiene for the purpose of providing a grant, not to exceed \$425,000, to the Maryland Medbank Program under § 15-124.2 of the Health - General Article.

**Effective Date: July 1, 2008**

**HOUSE BILL 1100 (Chapter 441) / SENATE BILL 701 (Chapter 440) – Insurance Producers – Life and Health Insurance Examinations – Annual Report**

- Requires that, on or before April 1 of each year, the Insurance Commissioner or a designee of the Insurance Commissioner shall prepare and publish a report that summarizes statistical information that relates to the life and health insurance producer examinations administered during the preceding calendar year.
- Specifies that the report shall include for all examinees combined and separately by race or ethnicity, gender, race or ethnicity within gender, educational level, and native language:
  - (1) the total number of examinees;
  - (2) the percentage and number of examinees who passed the examination;
  - (3) the mean scaled scores on the examination;
  - (4) the standard deviation of scaled scores on the examination; and
  - (5) the correct answer rate and correlation for each test question and each test form.

- Requires that, as soon as practicable after its publication, the Insurance Commissioner or a designee of the Insurance Commissioner shall submit the report to the Senate Finance Committee and the House Health and Government Operations Committee.

**Effective Date: October 1, 2008 - September 30, 2011**

**HOUSE BILL 1589 (Chapter 331) – Insurance Producers – Licensing Requirements**

- Removes the ability of the Commissioner to waive the requirement that the applicant for a license for property insurance or casualty insurance must pass an examination given by the Commissioner under Title 10, Subtitle 1 of the Insurance Article on the basis that the applicant has been conferred certain professional designations.
- Expands the list of professional designations for which the Commissioner may waive the pre-licensing education requirement for an applicant for a license for property insurance or casualty insurance to include the designations of Accredited Adviser in Insurance (AAI) or Associate in Risk Management (ARM).
- Permits the Commissioner to waive the requirement for pre-licensing education for life insurance for an applicant who has been conferred certain professional designations.
- Permits the Commissioner to waive the requirement for pre-licensing education for health insurance for an applicant who has been conferred certain professional designations.
- Removes the ability of the Commissioner to waive the examination requirement for life insurance for an applicant on the basis that the applicant has been conferred certain professional designations.
- Requires all resident licensees to complete 24 continuing education (CE) hours.
- Specifies that individuals with a title insurance producer license must complete 16 hours of continuing education per renewal period.
- Specifies that if an insurance producer has held a license for 25 or more consecutive years as of October 1, 2008, the Commissioner may not require the insurance producer to receive more than 8 hours of continuing education per renewal period.
- Requires that all insurance producers must receive three hours of CE in Ethics per renewal period.
- Alters the renewal date of an insurance producer license to be the last day of the month in which the holder of the license was born.
- Grants the Maryland Insurance Administration the needed flexibility to implement the new renewal date for producer licenses.
- Specifies that the new CE requirements shall apply to licenses renewed on or after October 1, 2009.
- Specifies that the new renewal date provisions do not take effect until January 1, 2009.

**Effective Date: October 1, 2008**

**SENATE BILL 297 (Chapter 571) – Tax Credit for Employer Established Work-Based Learning Programs for Students**

- Permits an insurance company to claim a credit against the premium tax for wages paid to each student under an approved paid work-based learning program as provided under § 21–501 of the Education Article.
- The provisions of Senate Bill 297 are applicable to all taxable years beginning after December 31, 2008.

***Effective date: July 1, 2008 - June 30, 2013***