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BULLETIN 24-15

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

Re: Summary of Insurance Laws Enacted in 2024

Date: June 5, 2024

The purpose of this Bulletin is to summarize laws enacted during the 2024 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration ("MIA"). ***The attached summary is intended only as notice of passage of the legislation and is not a representation of the MIA's interpretation of the new laws, nor is it a representation of how the MIA may enforce these new provisions.*** All regulated entities should refer to the Chapter Laws of Maryland for the 2024 Session for the complete text of these recently enacted laws. Regulated entities are advised that other bills passed by the General Assembly and not listed on the summary may also affect their business operations in Maryland.

You may obtain a copy of a specific law passed by the General Assembly during the 2024 Session by accessing the Maryland General Assembly's web site at mgaleg.maryland.gov or by contacting the Department of Legislative Services at (410) 946-5400. You should refer to the House or Senate Bill number when searching for a law on the web site. You may also obtain a copy of "The 90 Day Report – A Review of the 2024 Legislative Session" on the Internet or from Library and Information Services, Office of Policy Analysis, Department of Legislative Services.

For additional information concerning the MIA's summary of 2024 insurance legislation, please contact Jamie Sexton at Jamie.Sexton@maryland.gov

I. Life and Health Bills

HB0023 / SB0228 (Chs. 115 and 116) - Maryland Health Benefit Exchange – Qualified Health Plans – Dental Coverage
(MIA Departmental Bill)
Effective on January 1, 2025

- Amends §§ 31-115 and 31-116 of the Insurance Article to require all Qualified Health Plans offered on the Maryland Health Benefit Exchange to include coverage for pediatric dental essential health benefits.

HB0030 / SB0217 (Chs. 117 and 118) - Health Insurance - Conformity with Federal Law
(MIA Departmental Bill)
Effective on October 1, 2024

- Implements changes to both the Insurance and Health-General Articles to address recent updates to federal regulations related to the Affordable Care Act and the No Surprises Act.
- Clarifies the definitions of "Emergency Services" and "Emergency Medical Conditions" in §19-701(e) of the Health-General Article to mirror that of the *No Surprises Act* (NSA).
- Makes amendments to §§ 15-1A-01, 15-1A-03, 15-1A-04, 15-1A-14, and 15-1A-16 of the Insurance Article to:
    - Apply updated provisions related to choice of provider and coverage of emergency services to grandfathered plans;
    - Update the definition of "emergency medical conditions" to include a mental health condition or substance use disorder;
    - Clarify additional items and services that are not considered "emergency services," and
    - Update specified effective dates for new or revised federal regulations related to grandfathered plans, criteria for essential health benefits and discriminatory plan designs, and medical loss ratios.
- Amends § 15-1208.2 of the Insurance Article to revise the triggering event for a special enrollment period for small employers related to material errors.
- Amends § 15-1316 of the Insurance Article to implement a technical revision to the annual open enrollment period requirements for individual health benefit plans.

HB0571 / SB0485 (Chs. 267 and 266) - Family and Medical Leave Insurance Program - Modifications
Effective on October 1, 2024

- Amends Title 8.3 of the Labor and Employment Article to make modifications to Maryland's Family and Medical Leave Insurance (FAMLI) Program, by delaying the start dates for required contributions to July 1, 2025, and for benefit payments to July 1, 2026.

- Revises the section of the Act, § 8.3-705, that allows employers to satisfy the requirements of the law by offering a private employer plan through employer-provided benefits or insurance. The changes: require the Secretary of Labor to authorize an employer to use a private employer plan; remove the option for an employer to use a combination of employer provided benefits and insurance; and, require the plan to be provided to all eligible employees.
- Provides the Department of Labor authority to investigate and resolve complaints related to violations of this Act, including violations committed by insurers. If a violation is found, the Department has authority to impose a civil penalty of up to $1,000 for each employee of the employer found to be not in compliance.
- Authorizes the Department to assess an employer or insurer for the Department's costs of any appeal of an adverse decision when the covered individual prevails.

HB0676 (Ch. 960) - Right to Try Act - Individualized Investigational Treatments
Effective on October 1, 2024

- Amends the Right to Try Act in current law which authorizes manufacturers of investigational drugs, biological products, or devices to provide the manufacturer's investigational drug, biological product, or device to an eligible patient without compensation.
- Amends §§ 21-2B-01 through -06 of the Health - General Article (the Right to Try Act in current law) to repeal the definition of "investigational drug, biological product, or device" and replaces references to that term with "individualized investigational treatment," defined as a drug, biological product, or device that is unique to and produced exclusively for use by an individual based on the genetic profile of the individual.
- Alters the definitions of "eligible patient" to include individuals who have life-threatening or severely debilitating illnesses, rather than only individuals who have terminal illnesses. This would include individuals whose physician has recommended an individualized investigational treatment based on analysis of the individual's chromosomes and/or genetic information.
- Permits, but does not require, a carrier to provide coverage for the cost of an individualized investigational treatment or the cost of services related to the use of an individualized investigational treatment.

HB0728 / SB0705 (Chs. 842 and 841) - Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)
Effective on October 1, 2024

- Adds a new § 31-123 to the Insurance Article requiring the Maryland Health Benefit Exchange ("the Exchange"), in consultation with the Insurance Commissioner, and as approved by the Board, to submit a State Innovation Waiver application amendment under § 1332 of the Affordable Care Act to establish a Qualified Resident Enrollment Program ("the Program") and, if available, to seek federal pass-through funding resulting from the implementation of the Program.

- A “qualified resident” under the legislation is an individual, regardless of immigration status, who resides in Maryland, is not incarcerated, and is not eligible for the Federal Premium Tax Credit, the Maryland Medical Assistance Program, Medicare, the Maryland Children’s Health Plan, or any employer–sponsored minimum essential coverage.
- Adds a new § 31-124 to the Insurance Article requiring, within six months before a fiscal year in which the Exchange implements the Program, the Exchange to submit a report to the General Assembly on its plan to implement the Program, including (1) the amount and source of the funding; (2) the parameters of the Program; (3) the number of individuals anticipated to participate in the Program; (4) the amount of premiums anticipated to be paid by participants under the Program; and (5) if the General Assembly authorizes funding to subsidize premiums under the Program, the parameters of the subsidies.

HB0827 / SB0821 (Chs. 796 and 797) - Maryland Insurance Administration - Professional Employer Organizations - Study
Effective on July 1, 2024

- Requires the Maryland Insurance Administration to conduct a comprehensive study of professional employer organizations (PEOs) and submit a report to the General Assembly by December 31, 2024.
- The study will include the identification and comparison of the regulation of PEOs under federal and State law in and other states; the history of PEOs in the State and in other jurisdictions, including changes in the PEO industry over time; the review of PEO health plans and benefit designs; the review of the requirements related to the engagement of PEO services and access to PEO sponsored health plans that must be met by a business; the examination of which other states determine an employer’s group size at the level of the workplace employer, as well as the examination of regulatory structures for health insurance and PEOs under federal law; and address potential impacts to the Maryland small group market if Maryland were to change the current law regarding group size.

HB0865 / SB0614 (Chs. 822 and 823) - Maryland Medical Assistance Program and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)
Effective on January 1, 2025

- Amends § 15-844 of the Insurance Article, altering the term “prosthetic device” to “prosthesis” and expands the current mandated benefit to include coverage for a custom-designed, -fabricated, -fitted, or -modified device to treat partial or total limb loss for purposes of restoring physiological function. Also amends § 15-103 of the Health - General Article requiring that Medicaid provide coverage for prostheses in accordance with the same requirements applicable to carriers under § 15-844 of the Insurance Article.
- Requires a carrier to cover prosthesis if the treating health care provider determines that a prosthesis is medically necessary for completing activities of daily living, essential job-

related activities, or performing physical activities to maximize the whole-body health and lower or upper limb function of the insured or enrollee.

- A carrier must provide – once annually – coverage for prostheses, components of prostheses, and repairs to prostheses, as well as replacements of prostheses and prosthesis components. The coverage may not be subject to a higher copayment or coinsurance than for other similar medical and surgical benefits under the policy or contract.
- Uncodified Section 3 requires carriers and Medicaid MCOs, by June 30, 2030, to report to the MIA and MDH on their compliance with § 15-844 of the Insurance Article for calendar year 2025 through 2028. The report must be in a form that will be jointly prescribed by the MIA and MDH and include the number of claims and the total amount of claims paid in the State for coverage of prostheses for the MIA and MDH to aggregate the data. Requires the MIA and MDH, on or before December 31, 2030, to submit the joint report to the Senate Finance Committee and the House Health and Government Operations Committee.

HB0932 / SB0791 (Chs. 847 and 848) - Health Insurance - Utilization Review - Revisions
The statutory changes in Section 1 of the bill take effect on January 1, 2025, but the remainder of the bill has an effective date of July 1, 2024.

- Imposes new requirements on carriers and health care providers under § 19-108.5 of the Health-General Article related to the establishment of an online process for streamlining approvals for electronic prior authorization requests for pharmaceutical services and providing real-time patient-specific, benefit, and cost-sharing information.
- Amends § 15-854 of the Insurance Article to prohibit carriers from denying or requesting additional documentation for a reauthorization request for the same prescription drug if certain conditions are met. The prohibition only applies if the drug is an immune globulin or is used to treat a mental disorder; the drug has previously been approved for a patient who has been treated with the drug without interruption since the initial approval; and the provider attests that the drug continues to be necessary to effectively treat the patient's condition.
- Adds a new § 15-854.1 of the Insurance Article requiring a carrier to approve a prior authorization request for a course of treatment for a period of time long enough to avoid disruptions in care; and, for new enrollees in an active course of treatment, prohibits a carrier from disrupting or requiring a new authorization for at least 90 days after enrollment.
- Amends § 15-10A-02(b)(3) of the Insurance Article to specify the criteria for determining whether a grievance is considered an emergency case that qualifies for an expedited internal review procedure.
- Amends the criteria for the required contents of a notice of adverse decision or notice of grievance decision under §§ 15-10A-02 of the Insurance Article.
- Amends § 15-10A-06 of the Insurance Article to require carriers to include in their quarterly adverse decision and grievance reports to the Insurance Commissioner (1) whether the adverse decision involved a prior authorization or step therapy protocol; (2)

the number of adverse decisions overturned after a reconsideration request; and (3) the number of formulary exception requests made and granted.

- Modifies the existing parameters for a private review agent's utilization review criteria and standards under § 15-10B-05(a)(11) of the Insurance Article, adding several new requirements, including a certification by the private review agent that the criteria were developed by a nonprofit health care provider professional medical or clinical specialty society or other organization that works directly with health care providers in the same specialty for the designated criteria, as well as a requirement that the criteria must be reviewed, evaluated, and updated at least annually.
- Amends § 15-10B-06 of the Insurance Article to:
    - Specify the time periods within which a private review agent must make a determination for an emergency course of treatment or a request to authorize additional visits or days of care under an existing course of treatment
    - Impose additional time periods on private review agents in situations where the private review agent has insufficient information to make a determination on an authorization request
    - Require a private review agent to deem an authorization request approved if the determination is not made within the time periods required by statute
    - Impose new requirements for the peer-to-peer reconsideration process under Maryland law, and change it from an optional process to a mandatory process.
- Amends the required qualifications for individuals rendering adverse decisions and grievance decisions under §§ 15-10B-07 and 15-10B-09.1 of the Insurance Article to include a requirement that the individuals must have actual clinical experience related to the requested health care service or treatment.
- Requires the Maryland Health Care Commission and the Maryland Insurance Administration to conduct a joint study on the development of standards for the implementation of payor programs to modify prior authorization requirements for prescription drugs, medical care, and other health care services based on health care practitioner–specific criteria.

HB1074 / SB0684 (Chs. 234 and 233) - Health Insurance – Mental Health and Substance Use Disorder Benefits – Sunset Repeal and Modification of Reporting Requirements
Effective upon Enactment (Emergency Bill)

- Amends § 15-144 of the Insurance Article altering and expanding the reporting requirements for carriers to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("Parity Act"). The MIA issued Bulletin 24-10 to provide carriers with updated filing guidance for the NQTL analysis reports required to be submitted in 2024, in consideration of the statutory amendments.
- Requires carriers to submit a biennial compliance report beginning July 1, 2024, that includes specified information, including information on select nonquantitative treatment limitations (NQTLs), and results from a comparative analysis conducted by the carrier.

- Requires the Commissioner to develop, in accordance with § 15-144(f), new standardized data templates to evaluate the comparative analysis of certain NQTLs in operation.
- Repeals existing requirement for carriers to identify the five health benefit plans with the highest enrollment for each product and submit a separate report for each of those health benefit plans, and instead requires each carrier to submit an NQTL report for each product offered by the carrier in the individual, small, and large group markets.
- Establishes that a carrier has the burden of persuasion in demonstrating that its design and application of an NQTL complies with the Parity Act. Failure of a carrier to submit complete Parity Act compliance information constitutes noncompliance with the Parity Act.
- Authorizes the Insurance Commissioner to take additional actions to enforce compliance with reporting requirements.

HB1259 (Ch. 868) - Health Insurance - Breast and Lung Cancer Screening - Coverage Requirements
Effective on January 1, 2025, and applies to all policies, contracts and health benefit plans issued, delivered or renewed in the State on or after this date.

- Amends § 15-814.1 of the Insurance Article to include "image-guided breast biopsy" in the definition of "supplemental breast examination," prohibiting carriers that provide coverage for such examinations from imposing a copayment, coinsurance, or deductible requirements, with specified exemptions. Due to federal requirements related to health savings account-qualified high deductible health plans (HDHPs), if an insured or enrollee is covered under an HDHP, a carrier may subject such examinations to the HDHP's deductible requirement.
- Amends § 15-860 to mandate coverage for recommended lung cancer screening for individuals for whom lung cancer screening or follow-up diagnostic imaging is recommended by the U.S. Preventive Services Task Force. This coverage may not be subject to a prior authorization requirement.

HB1337 (Ch. 891) - Health Insurance - Appeals and Grievances Process - Reporting Requirements
Effective on July 1, 2024

- Amends § 15-10A-06 of the Insurance Article to require carriers to include in their quarterly reports to the Insurance Commissioner (1) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier, and (2) the number of clean claims for reimbursement processed by the carrier.

HB1339 / SB0778 (Chs. 951 and 952) - Health Insurance - Hearing Aids for Adults - Coverage
Effective on January 1, 2025, and applies to all policies, contracts and health benefit plans issued, delivered or renewed in the State on or after this date.

- Amends § 15-838 and adds a new § 15-838.1 to the Insurance Article creating a mandated benefit for coverage of all medically appropriate and necessary hearing aids for adults if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.
- Carriers may limit the benefit payable to $1,400 per hearing aid for each hearing-impaired ear every 36 months. Carriers are not prohibited from providing coverage that is greater than $1,400 or more favorable to an insured or enrollee.
- An insured or enrollee may choose a hearing aid that is priced higher than the benefit payable under this subsection and may pay the difference between the price of the hearing aid and the benefit payable under this subsection, without financial or contractual penalty to the provider of the hearing aid.

HB1397 (Ch. 377) - Civil Rights - Discrimination Based on Protected Characteristics and Reproductive Freedom
Effective upon Enactment (Emergency Bill)

- Amends §§ 15-112 and 27-910 of the Insurance Article to prohibit a carrier from denying an application for participation or terminate participation on its provider panel on the basis of sex, sexual orientation, or gender identity and to prohibit a health network from denying health care services on the basis of sex, sexual orientation, or gender identity.
- Expands the prohibition on discrimination by a Health Maintenance Organization (HMO) in the offering of or termination of health care services to include discrimination based on sexual orientation, gender identity, religious beliefs, or disability in § 19-710 of the Health-General Article. Amends § 19-725 of the Health - General Article to prohibit an HMO from canceling or refusing to transfer a member from a group to an individual contract because of sexual orientation, gender identity, or disability.

HB1521 (Ch. 47) - Maryland Children's Health Program - Eligibility and Administration
Effective upon Enactment (Emergency Bill)

- Amends and repeals the eligibility requirements for the Maryland Children's Health Program (MCHP) and eliminates the MCHP premium plan in §§ 13-301 and 15-301.1 of the Health - General Article. As a result, individuals under the age of 19 with family income at or below 300 percent of FPL, who do not qualify for the Maryland Medical Assistance Program, are eligible under MCHP with no required premium.
- Repeals outdated language from §§ 15-1213(d) and 15-1406(e) of the Insurance Article to remove reference to legacy coverage groups for the MCHP private option plan, which sunset in 2003.

SB1103 (Ch. 142) - Hospitals and Related Institutions - Outpatient Facility Fees
Effective on July 1, 2024

- Requires the Health Services Cost Review Commission (HSCRC), in consultation with MDH, MIA, and the HEAU within the OAG's office, to study and make recommendations regarding hospital outpatient facility fees and submit a preliminary report to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2024, and December 1, 2025, respectively.

II. Property and Casualty Bills

HB0647 (Ch. 740) - Property and Casualty Insurance – Pet Insurance – Regulation
Effective on January 1, 2025, and applies to all policies and contracts of pet insurance issued, delivered or renewed in the State on or after this date.

- Creates new §§ 19-1101 through 19-1107 in the Insurance Article establishing new regulatory requirements for pet insurance.
- Requires a pet insurer, at the time a pet insurance policy is issued or delivered to a policy holder, to disclose: (1) all policy exclusions, including exclusions of coverage due to specified preexisting conditions or disorders; (2) any policy provision that limits coverage through a waiting period, a deductible, coinsurance, or an annual or lifetime policy limit; (3) whether the pet insurer reduces coverage or increases premium based on the insured's claim history, the age of the covered pet, or a change in the geographic location of the insured; and (4) the identity of the underwriting company if the company differs from the brand name used to market and sell the pet insurance policy.
- Requires the MIA to develop informational material about pet insurance policies that may be disseminated to and posted by veterinary practitioners in the state by June 1, 2025.

HB1227 (Ch. 296) Condominiums - Mandatory Insurance Coverage - Detached Units
Effective on October 1, 2024

- Amends § 11-114 of the Real Property Article to alter the types of elements and units for which a council of unit owners is required to maintain certain property insurance and limits the instances when an owner of a detached unit within a condominium is required to carry homeowners insurance on the entirety of the unit.
- Amends the prior requirement that all unit owners obtain homeowners insurance to instead only require an owner of a residential detached unit located within a condominium composed entirely of similar detached units to carry homeowners insurance coverage.
- Clarifies that a council of unit owners may carry insurance coverage on the entirety of all detached units located within a condominium composed entirely of similar detached units, to satisfy the requirements of the law. If the council does not cover the entirety of all detached units, the owner of a residential, detached unit is required to carry homeowners insurance coverage on the entirety of the unit.

HB1482 (Ch. 857) - Uninsured Driving Penalties - Funding for the Maryland Automobile Insurance Fund, Driver Education, and Transportation to Field Trips
Effective on July 1, 2024

- Amends § 17-106 of the Transportation Article by increasing the uninsured motorist penalties that apply when required insurance on a motor vehicle registered in Maryland terminates or otherwise lapses during its registration period.
- Insurers will be required to update their forms to reflect new penalty amounts, if necessary. Insurers with filed forms that have the referenced penalty amounts specified as a static field will be required to refile those forms with the MIA.

III. General Bills

HB0036 (Ch. 826) - Insurance - Protections After Loss or Damage to Property
(MIA Departmental Bill)
Effective on October 1, 2024

- Amends § 10-414 of the Insurance Article to prohibit a public adjuster, or anyone acting on behalf of a public adjuster, from soliciting or attempting to solicit a client between the hours of 8:00 p.m. and 8:00 a.m. Also requires a notice be added to public adjuster contracts making the insured party signee of the contract aware of the hours in which public adjuster solicitation is not allowed.
- Lengthens an insured's right to rescind or cancel a public adjuster contract from 3 to 10 business days after the date the contract was signed, and requires notice of this right be contained in a statement in the contract.
- Requires a public adjuster who enters into a public adjuster contract during, or within 72 hours after, a loss giving rise to an insurance claim, to provide notice to the Insurance Commissioner that they have entered into the contract. The notice must be provided to the Commissioner within 1 business day after entering into the contract, in a form and manner the Commissioner determines.
- Amends § 27-407.2 of the Insurance Article by striking the limitation that the contractor's fraudulent conduct must be related to damages to a private residence "caused by weather."

HB0067 / SB0229 (Chs. 119 and 120) - Insurance - Penalties - Unauthorized Insurers, Insurance Producers, and Public Adjusters
(MIA Departmental Bill)
Effective on October 1, 2024

- Amends § 4-212 of the Insurance Article to increase the maximum civil penalty from $50,000 to $125,000 for each violation in which an unlicensed person engages in the business of insurance in the State.

- Increases the maximum penalty that can be imposed on insurance producers (Ins. § 10-126) and public adjusters (Ins. § 10-410) from $500 to $5,000 per violation of the Insurance Article.

HB0090 / SB0230 (Chs. 827 and 828) - Insurance - Hearing Representation
(MIA Departmental Bill)
Effective on October 1, 2024

- Amends § 2-213 of the Insurance Article to permit a "business entity" (defined as a corporation, partnership, limited liability company, or sole proprietorship) that meets the definition of a "small employer" in § 31-101 in the Insurance Article (employers of not more than 50 employees) to designate an officer of the corporation, a partner in the partnership, a member of the limited liability company, or specified designated employees to represent them in administrative proceedings before the MIA or hearings at the Office of Administrative hearings on behalf of the MIA. This eliminates the need for small businesses from engaging counsel to represent them in administrative proceedings before the MIA.

HB0229 / SB0254 (Chs. 73 and 74) - Vehicle Laws - Motor Vehicle Insurance Companies - Requirements
Effective on January 1, 2025

- Amends § 17-104 of the Transportation Article to require all motor vehicle insurers to participate in the Motor Vehicle Administration's (MVA) new online verification program for motor vehicle liability insurance policies.
- Requires all active insurance policies to be electronically submitted to the MVA in the format and interval required by the MVA.

HB0265 / SB0336 (Chs. 874 and 873) - Insurance - Producer Licensing Requirements - Education and Experience
Effective on October 1, 2024

- Amends Title 10, subtitle 1 of the Insurance Article repealing education and experience requirements for producer applicants, specifically those that require an individual to take a prelicensing course and work for at least one year prior to applying for an insurance producer license.
- This law does not make changes to the current requirements to obtain an insurance producer license, specifically that the applicant: (1) be trustworthy and of good character; (2) be at least 18 years old; (3) pass a written examination related to the type of insurance for which the license is being requested; and (4) pay the initial license fee.

HB0567 / SB0541 (Chs. 454 and 455) - Maryland Online Data Privacy Act of 2024
Effective October 1, 2025

- Amends § 13-301, and adds a new subtitle 46 (§§ 14-4601 through 14-4614) to the Commercial Law Article, establishing the Online Data Privacy Act ("the Act"), to provide comprehensive regulation of multiple aspects of online commercial usage of personal data by persons who are legitimately in possession thereof. Violation of the Act is an unfair, abusive, or deceptive trade practice under the Maryland Consumer Protection Act.
- The Act does not apply to personal data collected by or on behalf of a person regulated under the Insurance Article or an affiliate of such person, in furtherance of the business of insurance.
- The Act also does not apply to a financial institution, an affiliate of a financial institution, or data that is subject to Title V of the federal Gramm-Leach Bliley Act and regulations adopted under that Act.

HB0887 / SB0694 (Chs. 795 and 794) - Maryland Department of Health - Health Commissions and Maryland Insurance Administration - Study
Effective on October 1, 2024

- Requires MDH to contract with an independent consultant to analyze the duties of the Health Services Cost Review Commission (HSCRC), Maryland Health Care Commission (MHCC), MIA, and the Maryland Community Health Resources Commission (MCHRC) to identify overlap between agencies; identify whether any of the duties may be more appropriate for MDH or another agency; identify whether the agencies under study and their functions can be streamlined to improve effectiveness and efficiency; examine how the duties of the studied agencies align with the Maryland Total Cost of Care Model and the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model; and recommend any changes in the agencies administrative structure.
- The independent consultant is required to seek input from the referenced agencies, and report the results by January 1, 2026.

IV. Financial Regulation

HB0252 (Ch. 121) - Insurance - Holding Companies - Group Capital Loss & Liquidity Stress Test
(MIA Departmental Bill)
Effective on October 1, 2024

- Amends §§ 7-101, 7-106, and 7-603 of the Insurance Article to reflect 2020 revisions made by the National Association of Insurance Commissioners (NAIC) to its Model Act #440 "Insurance Holding Company System Regulatory Act."
- Requires each insurer subject to registration pursuant to § 7-603 of the Insurance Article to concurrently file with its registration statement an annual Group Capital Calculation ("GCC") as directed by the Lead State Commissioner of the Insurance Group.

- Requires the controlling person of a large life insurer in an insurance holding company to file - concurrent with the registration statement - the results of a liquidity stress test ("LST") with the Lead State Commissioner of the Insurance Group.
- Requires the Commissioner to maintain the confidentiality of the GCC, GCC-related information, LST results, and LST-related information.
    - The data, information, and materials collected by the MIA for the GCC or LST is (1) recognized as being proprietary and to contain trade secrets; (2) confidential and private; (3) not subject to the Public Information Act; (4) not subject to subpoena; and (5) not subject to discovery or admissible in evidence in any private civil action.
- This Act ensures that the MIA maintains NAIC accreditation by incorporating these Model Act changes, which are effective January 1, 2026.