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Governor

MICHAEL S. STEELE
Lt. Governor



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BULLETIN 06-12

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

Re: Summary of 2006 Insurance Legislation Signed into Law by Governor Robert L. Ehrlich, Jr.

Date: July 1, 2006

This summary is meant to place insurers, non-profit health service plans, and health maintenance organizations authorized to do business in Maryland on notice of the insurance laws (Insurance Article, § 1-101, *et seq.*, Annotated Code of Maryland) passed by the 2006 Maryland General Assembly. ***The attached synopsis is intended to serve only as a guide.*** All insurers, non-profit health service plans, and health maintenance organizations should refer to the 2006 Chapter Laws of Maryland for the complete text of any of these recently enacted laws. Insurers, non-profit health service plans, and health maintenance organizations are advised that other bills passed by the General Assembly and not listed on the synopsis may also affect their business operations in Maryland.

You can obtain a copy of a specific law passed by the General Assembly during the 2006 legislative session by accessing <http://mlis.state.md.us> on the internet or by contacting the Department of Legislative Services at 410-946-5400. You should refer to the House or Senate Bill number when searching for a law on the "mlis" web site. You can also obtain a copy of *The 90 Day Report -- A Review of the 2006 Legislative Session* from Library and Information Services, Office of Policy Analysis, Department of Legislative Services, 90 State Circle, Annapolis, MD 21401-1991 (410-946-5400).

For additional information concerning the Maryland Insurance Administration's Summary of 2006 Insurance Legislation, please contact Brett Lininger, Director of Government Relations, at 410-468-2014.

2006 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 549 (Chapter 331) - Health Insurance - Private Review Agents - Emergency Inpatient and Residential Crisis Services Admission Determinations

- Requires that, when applicable, a private review agent submit to the Insurance Commissioner its procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of the Insurance Article, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination.
- Requires a private review agent that requires prior authorization for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of the Insurance Article, for the treatment of a mental, emotional, or substance abuse disorder to:
 - (1) make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, within 2 hours after receipt of the information necessary to make the determination; and
 - (2) promptly notify the health care provider of the determination.
- Prohibits a private review agent from rendering an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:
 - (1) the admission is an involuntary admission under §§ 10-615 and 10-617(a) of the Health - General Article; and
 - (2) the hospital immediately notifies the private review agent of:
 - (a) the admission of the patient; and
 - (b) the reasons for the admission.

Effective date: October 1, 2006

HOUSE BILL 702 (Chapter 345) - Maryland Health Insurance Plan - Senior Prescription Drug Assistance Program

- Adds funding for the Senior Prescription Drug Assistance Program (“Program”) for fiscal year 2008 of up to \$14 million.
- Clarifies that the Senior Prescription Drug Assistance Program shall provide a prescription drug benefit subsidy, as determined by the Board, that may pay all or some of the deductibles, coinsurance payments, premiums, and copayments under the federal Medicare Part D Pharmaceutical Assistance Program for enrollees of the Program.
- Clarifies that the Program may annually provide an additional subsidy, up to the full amount of the Medicare Part D Prescription Drug Plan premium, for individuals who qualify for a partial federal low-income subsidy.
- Requires the Senior Prescription Drug Assistance Program to maintain a waiting list of individuals who meet the eligibility requirements for the Program but who are not served by the Program due to funding limitations.
- Requires the Board to determine annually:
 - (1) the number of individuals to be enrolled in the Program;
 - (2) the amount of subsidy to be provided under the Program; and
 - (3) the amount of any additional subsidy provided under the Program.
- Requires that on or before January 1 of each year, the Board shall report to the General Assembly on:
 - (1) the number of individuals on the waiting list for the Program; and
 - (2) to the extent that the Board is able to collect the information:
 - (a) the number of enrollees with out-of-pocket prescription drug costs that exceed \$2,250, broken down for each fiscal quarter; and
 - (b) the total annual out-of-pocket prescription drug costs for enrollees.
- Permits the Board of the Maryland Health Insurance Plan to structure the benefit subsidy under the Senior Prescription Drug Assistance Program to cover any out-of-pocket costs an enrollee in the Program may incur for prescription drugs during calendar year 2006.

- Prohibits the Maryland Health Insurance Plan from spending any remaining funds from the Senior Prescription Drug Assistance Program that may accrue to the account of the Senior Prescription Drug Assistance Program without the approval of the General Assembly.
- Specifies that the Act applies to all individuals enrolled in the Senior Prescription Drug Assistance Program beginning January 1, 2006.

Effective date: May 2, 2006 (Emergency Bill)

HOUSE BILL 868 (Chapter 476) - Health Insurance - Participation of Health Care Providers on Provider Panels - Workers' Compensation Services

- Prohibits a carrier that uses a provider panel for health care services from requiring a health care provider, as a condition of participation or continuation on the carrier's provider panel for health care services, to also serve on a provider panel for workers' compensation services.
- Prohibits a carrier from terminating, limiting, or otherwise impairing a contract or an agreement with a health care provider, or terminating or limiting the employment of a health care provider, based on the health care provider's election not to serve on a provider panel for workers' compensation services.
- Requires a carrier to include in a contract or an agreement with a health care provider a disclosure that informs the health care provider of the right to elect not to serve on a provider panel for workers' compensation services.
- Specifies that this Act shall apply to contracts or agreements between health insurance carriers and health care providers that are executed on or after July 1, 2006 and that this Act may not be construed to authorize a health care provider to terminate, limit, or otherwise impair any contract or agreement with a health insurance carrier that was executed on or before June 30, 2006.

Effective date: July 1, 2006

HOUSE BILL 1003 (Chapter 597) - Health Insurance - Carrier Provider Panels - Participation by Providers

- Requires a carrier that is an insurer, nonprofit health service plan, or dental plan organization to maintain standards in accordance with regulations adopted by the Insurance Commissioner for availability of health care providers to meet the health care needs of enrollees.

- Requires a carrier that is a health maintenance organization to adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19-705.1(b)(1)(ii) of the Health - General Article.
- Requires a carrier that uses a provider panel to establish procedures to verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide.
- Requires that a carrier update its provider information under § 15-112(j)(3)(ii) of the Insurance Article within 15 working days after receipt of written notification from the participating provider of a change in the applicable information.
- Specifies that notification is presumed to have been received by a carrier:
 - (1) three working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or
 - (2) on the date recorded by the courier, if the notification was delivered by courier.
- Requires that each carrier establish and implement a procedure by which a member may request a referral to a specialist who is not part of the carrier's provider if:
 - (1) the member is diagnosed with a condition or disease that requires specialized medical care; and
 - (2) the carrier cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.
- Requires that, for purposes of calculating any deductible, copayment amount, or coinsurance payable by the member, a carrier shall treat services received in accordance with § 15-830(d) of the Insurance Article as if the service was provided by a provider on the carrier's provider panel.
- Requires that, on or before January 1, 2007, the Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene's Office of Health Care Quality and other interested and affected parties, shall adopt regulations to implement the provisions of § 15-112(b)(1)(i)1 of the Insurance Article, with respect to insurers, nonprofit health service plans, and dental plan organizations.
- Requires the Maryland Insurance Administration to take into consideration the standards and procedures adopted by national accrediting organizations for preferred provider organizations and the laws of other states in developing the regulations.

- Requires that each insurer, nonprofit health service plan, and dental plan organization offering preferred provider organization benefit plans in the State shall comply with the regulations on or before July 1, 2007.
- Requires that, on or before January 1, 2008, the Maryland Insurance Administration shall study the feasibility and desirability of imposing on carriers a network standard for in-network hospital-based physician services, and report on the findings and recommendations of its study to the Senate Finance Committee and the House Health and Government Operations Committee.

Effective date: June 1, 2006

HOUSE BILL 1342 (Chapter 492) - Long-Term Care Planning Act of 2006

- Requires that, on or before January 1, 2007, the Secretary of the Department of Health and Mental Hygiene and the Insurance Commissioner report to the General Assembly on the implementation of the Maryland Partnership for Long-Term Care Program (“Program”), including:
 - (1) the number of long-term care policies approved by the department for inclusion in the Program;
 - (2) the measures undertaken to educate the public as required under § 15-406 of the Health – General Article; and
 - (3) any other information related to the implementation of the Program that the department determines necessary.
- Requires that, beginning January 1, 2008, and on or before January 1 of each year thereafter, the Secretary of the Department of Health and Mental Hygiene and the Insurance Commissioner report to the General Assembly on:
 - (1) the effectiveness of the Program;
 - (2) the impact of the Program on State expenditures for medical assistance;
 - (3) the number of enrollees in the Program; and
 - (4) the number of long-term care policies offered in the State.
- Requires the Maryland Health Care Commission to study the long-term care delivery system in the State to:

- (1) determine the types of services and programs that the age 65 and older population and individuals with disabilities will need in 2010, 2020, and 2030; and
 - (2) identify how the State should begin planning for needed services and programs.
- Requires that, in conducting the study, the Commission shall review:
 - (1) population projections for the age 65 and older population and for individuals with disabilities;
 - (2) the services and programs operated by State agencies for the age 65 and older population and for individuals with disabilities, including services and programs related to housing, transportation, medical needs, and food subsidies, to identify:
 - (a) problems with the delivery of existing services or programs; and
 - (b) the need for additional services or programs;
 - (3) the adequacy of current services and programs for the age 65 and older population and for individuals with disabilities provided by each county and region in the State and any gaps in services;
 - (4) the effect that the growth of the age 65 and older population will have on current services and programs and the areas of the State that will be most affected;
 - (5) the type of services and programs that will be most needed to support individuals with disabilities and to care for the age 65 and older population in 2010, 2020, and 2030;
 - (6) the affordability of the types of services and programs for the age 65 and older population and for individuals with disabilities who may not qualify for federal, State, or local assistance; and
 - (7) the cost to the State to provide services and programs to the age 65 and older population and individuals with disabilities.
 - Permits the Commission to contract with a private entity to conduct the required study.
 - Requires the Commission to submit a final report on or before December 1, 2007, on its findings and recommendations to the Governor and the General Assembly.

Effective date: July 1, 2006

HOUSE BILL 1405 (Chapter 395) - Health Insurance - Coverage for Part-Time Students with Disabilities

- Prohibits insurers, nonprofit health service plans and health maintenance organizations that provide health benefits to full-time students over the age of 18 from excluding health benefits for a student over the age of 18 who:
 - (1) is enrolled less than full time as a result of a documented disability that prevents the student from maintaining a full-time course load; and
 - (2) is maintaining a course load of at least 7 credit hours per semester.
- Permits an insurer, nonprofit health service plan or health maintenance organization to require the insured, subscriber, or enrollee to provide verification of the disability from a disability services professional employed by the institution of higher education that the student attends or a health care provider with special expertise in and knowledge of the disability.

Effective date: October 1, 2006

SENATE BILL 60 (Chapter 21) - Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care - Extension and Modifications

- Authorizes the appointment of any additional individuals approved by a majority of the voting members of the Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care as nonvoting members.
- Authorizes the Task Force to appoint subcommittees to conduct more detailed studies of specific subjects within the jurisdiction of the Task Force.
- Alters the date that the Task Force must report its findings from December 31, 2005 to December 31, 2006.
- Extends the sunset date of the Task Force from June 30, 2006 to June 30, 2007.

Effective date: June 1, 2006

SENATE BILL 158 (Chapter 43) - Private Review Agents - Treatment Plan Form - Form Mandated by Another State

- Requires a Private Review Agent to accept a treatment plan form mandated by the state in which a service was provided if the service was provided in another state.

Effective date: October 1, 2006

SENATE BILL 284 (Chapter 242) - Health Insurance - Maryland Health Insurance Plan - Authority

- Permits the Maryland Health Insurance Plan Board of Directors to charge different premiums based on the benefit package delivery system when more than one benefit package delivery system is offered.
- Requires a carrier who denies coverage under a medically underwritten health benefit plan to an individual in the non-group market to provide the Maryland Health Insurance Plan with:
 - (1) the name and address of the individual who was denied coverage; and
 - (2) if the individual applied for coverage through an insurance producer, the name and, if available, the address of the insurance producer.
- Provides that the provisions of § 15-1303(c)(1) of the Insurance Article may not take effect until the receipt of an exception determination from the Secretary of Health and Human Services from § 160.203 of the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations that would allow carriers to provide the information specified in § 15-1303(c)(1) to the Maryland Health Insurance Plan.

Effective date: October 1, 2006

SENATE BILL 300 (Chapter 516) - Life Insurance - Insurable Interests - Trustees, Partnerships, Limited Partnerships, and Limited Liability Companies

- Specifies that the trustee of a trust has an insurable interest in the life of an individual insured under a life insurance policy owned by the trust or the trustee of a trust if, on the date on which the policy is issued:
 - (1) the insured is:
 - (a) the grantor of the trust;
 - (b) an individual related closely by blood or law to the grantor; or
 - (c) an individual in whom the grantor otherwise has an insurable interest; and
 - (2) the life insurance proceeds are primarily for the benefit of trust beneficiaries having an insurable interest in the life of the insured.
- Specifies that a partnership, limited partnership, or limited liability company has an insurable interest in the life of an individual insured under a life insurance policy owned by the partnership, limited partnership, or limited liability company if, on the date on which the policy is issued, substantially all of the owners of the partnership, limited partnership, or limited liability company are:

- (1) the insured;
 - (2) individuals related closely by blood or law to the insured; or
 - (3) persons having an insurable interest in the life of the insured.
- Applies to trusts existing before, on, or after June 1, 2006, regardless of the effective date of the governing instrument under which the trust was created, but only to life insurance policies that are in force and for which the insured is alive on or after June 1, 2006.

Effective date: June 1, 2006

SENATE BILL 325 (Chapter 26) - Joint Legislative Task Force on Small Group Market Health Insurance - Report and Modification of Duties

- Requires the Joint Legislative Task Force on Small Group Health Insurance to study the use of a state-subsidized reinsurance pool to lower prices in the small group market and the feasibility of establishing a health insurance exchange to strengthen the small group market in addition to its other study items.
- Alters the date that the Joint Legislative Task Force on Small Group Health Insurance must report its findings from January 1, 2006 to July 1, 2007.

Effective date: July 1, 2006

SENATE BILL 418 (Chapter 50) - Joint Committee on Access to Mental Health Services - Membership

- Increases the number of members on the Joint Committee on Access to Mental Health Services from eight to ten by adding a member of the House Judiciary Committee and a member of the Senate Judicial Proceedings Committee to the Joint Committee.

Effective date: June 1, 2006

SENATE BILL 491 (Chapter 259) - Health Insurance - Coverage for Home Visits After Mastectomy or Surgical Removal of a Testicle - Repeal of Sunset

- Repeals the sunset provision from Chapter 120 of the Acts of 1999, as amended by Chapter 59 of the Acts of 2003, which would have abolished § 15-832 of the Insurance Article.

Effective date: July 1, 2006

**SENATE BILL 636 (Chapter 54) - Health Insurance - Credentialing and
Recredentialing of Health Care Providers**

- Reduces the time frame in which a carrier must accept or reject a provider for participation on the carrier's provider panel and send written notice of the acceptance or rejection to the provider at the address listed in the application from 150 days to 120 days.
- Prohibits a carrier from requiring a provider participating on its provider panel to be recredentialed based on:
 - (1) a change in the federal tax identification number of the provider;
 - (2) a change in the federal tax identification number of a provider's employer; or
 - (3) a change in the employer of a provider, if the new employer is a participating provider on the carrier's provider panel or the employer of providers that participate on the carrier's provider panel.
- Requires a provider that participates on a carrier's provider panel or the provider's employer to give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.
- Specifies what must be included in the notice to the carrier of a change in the federal tax identification number.
- Requires that within 30 business days after receipt of the notice of change of federal tax identification number a carrier:
 - (1) shall acknowledge receipt of the notice to the provider or the provider's employer; and
 - (2) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to the provider or the provider's employer or to the representative of the provider or the provider's employer designated in writing to the carrier.
- Prohibits a carrier from terminating its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with § 15-112(f-1)(6) of the Insurance Article.
- Requires the Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene, the Maryland Board of Physicians, and

representatives of nonprofit health service plans, health insurers, health maintenance organizations, physicians, practice managers, hospitals, and other health care providers, to:

- (1) compare the credentialing system for health care providers used in the State to the systems used in other states;
 - (2) compare the uniform credentialing form used in the State to the format used by the Council for Affordable Quality Healthcare;
 - (3) identify the mechanisms used by physicians and other health care providers to complete credentialing; and
 - (4) identify ways to improve the credentialing system used in the State.
- Requires the Maryland Insurance Administration to report its findings to the Senate Finance Committee and the House Health and Government Operations Committee, on or before January 1, 2007.

Effective date: October 1, 2006

SENATE BILL 689 (Chapter 146) - Insurance - Viatical Settlements

- Requires that at the time of each application for a viatical settlement, a viatical settlement broker shall provide to the viator a written disclosure that, at a minimum, contains a description of the services required by statute to be provided by the viatical settlement broker to the viator.
- Prohibits a viatical settlement broker from purchasing a policy that is the subject of a viatical settlement brokerage contract between the viatical settlement broker and a viator directly or indirectly through:
 - (1) a person owning or controlling an interest in the viatical settlement broker; or
 - (2) a person in which any interest is owned or controlled by the viatical settlement broker.
- Requires a viatical settlement broker to submit to the viator all offers, counteroffers, acceptances, and rejections relating to the placement of the viator's policy within 72 hours after receipt by the viatical settlement broker.
- Requires a viatical settlement broker to provide to the viator a written disclosure of the amount and method of calculating the viatical settlement broker's compensation, including anything of value received by a viatical settlement broker for the placement

of a policy no later than 72 hours before the viatical settlement contract is signed by all parties to the contract.

- Requires disclosure to a viator to contain a description of the statutory fiduciary duty of a viatical settlement broker to a viator.
- Requires an insurer to respond to a request for verification of coverage submitted by a viatical settlement provider or a viatical settlement broker under this subtitle, including verification of whether the insurer intends, at the time of the request, to pursue an investigation regarding possible fraud affecting the validity of a policy, within 30 days after the request is received, if the following documents are submitted with the request:
 - (1) an authorization signed by the viator; and
 - (2) a "Verification of Coverage for Life Insurance Policies" form adopted by the Insurance Commissioner that has been completed by the viatical settlement provider or viatical settlement broker.
- Prohibits an insurer from charging a fee for responding to a request for verification of coverage submitted by a viatical settlement provider or a viatical settlement broker that exceeds \$50.
- Permits an insurer to send an acknowledgment of receipt of a request for verification of coverage, which may contain a general description of any accelerated death benefit that is available under the policy, to the viator and, if the viator is other than the insured, to the insured.
- Requires the Insurance Commissioner to adopt by regulation a "Verification of Coverage for Life Insurance Policies" form.
- Requires that the initial "Verification of Coverage for Life Insurance Policies" form required under § 8-610.1 of the Insurance Article be the form that appears in Appendix B of the Viatical Settlements Model Regulation adopted by the National Association of Insurance Commissioners.
- Specifies that nothing in this Act shall affect the jurisdiction of the Securities Commissioner of the Office of the Attorney General.

Effective date: July 1, 2006

SENATE BILL 728 (Chapter 266) - Telemedicine - Use and Reimbursement - Study

- Requires the University of Maryland, School of Medicine, in consultation with the School of Nursing and other stakeholders, to study issues regarding the use of and reimbursement for telemedicine, including the following:

- (1) the current use of telemedicine in the State;
 - (2) the use of and reimbursement for telemedicine in other states;
 - (3) the potential for telemedicine to improve access to health care in underserved areas of the State;
 - (4) how any reimbursement for telemedicine in other states has increased access to health care in those states; and
 - (5) any current barriers in the State to reimbursement for telemedicine.
- Requires the University of Maryland, School of Medicine to report its findings to the Senate Finance Committee and the House Health and Government Operations Committee on or before January 1, 2007.

Effective date: July 1, 2006

SENATE BILL 770 (Chapter 272) - Air Ambulance Services - Study

- Requires the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission and the Maryland Institute for Emergency Medical Services Systems, and with the assistance of the Office of the Attorney General, to study:
 - (1) the financial aspects of inter-hospital patient transfer and scene transport by air ambulance services operating in Maryland, including:
 - (a) the types and costs of operations;
 - (b) charges for services provided, including billing practices; and
 - (c) reimbursement by payors;
 - (2) state and federal laws applicable to the operation of air ambulance services in the State; and
 - (3) mechanisms available to the State to regulate financial aspects of air ambulance services and to ensure cost-effective use of air ambulance services for inter-hospital patient transfer and scene transport.
- Requires that on or before December 1, 2006, the Maryland Health Care Commission, the Health Services Cost Review Commission, and the Maryland Institute for Emergency Medical Services Systems shall submit a report on the study and any findings and recommendations to the Governor and to the Senate Finance Committee and the House Health and Government Operations Committee.

Effective date: July 1, 2006

SENATE BILL 1086 (Chapter 554) - Health Insurance - Contracts of Carriers with Providers, Ambulatory Surgical Facilities, or Hospitals - Prohibited Provisions

- Creates § 15-112(m) of the Insurance Article which prohibits a carrier from including in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:
 - (1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;
 - (2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or
 - (3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.
- Makes violation of § 15-112(m) of the Insurance Article an unfair method of competition and an unfair and deceptive act or practice in the business of insurance.

Effective date: October 1, 2006

PROPERTY AND CASUALTY

HOUSE BILL 285 (Chapter 454) - Homeowner's Insurance - Underwriting, Premium Increases, Cancellation, and Refusal to Renew

- Prohibits an insurer selling a homeowner's insurance policy from refusing to underwrite a risk, increase a premium, or cancel or refuse to renew coverage based on an inquiry by an insured or an insurance producer on behalf of an insured, that does not result in the payment of a claim.
- Defines inquiry to mean "a telephone call or other communication to an insurer regarding the terms and conditions of a homeowner's insurance policy, including a telephone call or other communication about whether the policy provides coverage for a particular loss or the process for filing a claim."

Effective date: October 1, 2006

HOUSE BILL 570 (Chapter 580) - Insurance - Notice - Cancellation, Nonrenewal, and Premiums

- Establishes a 45-day underwriting period for a binder or policy, other than a renewal, of private passenger motor vehicle, homeowners, dwelling, credit loss, or commercial property insurance, or liability insurance.
- Allows an insurer to cancel a binder or policy if the risk does not meet the insurer's underwriting standards during the underwriting period.
 - Requires an insurer to give at least 15 days' written notice of cancellation stating clearly and specifically the insurer's actual reason for the cancellation.
- Requires an insurer, at time of application or when a binder or policy is issued, to give written notice of its ability to cancel a binder or policy during the underwriting period.
- Increases the time frame, from 10 days to 15 days, an insurer must give a lender and insured consumer borrower a notice of cancellation of a binder given to a consumer borrower to satisfy a lender's requirement that the borrower obtain property insurance or credit loss insurance as a condition of making a loan secured by a first mortgage or first deed of trust interest in owner-occupied residential real property.
 - Modifies the disclosure provision regarding the notice of cancellation to reflect the new 15-day time frame.
 - Requires an insurer to issue a policy or provide the required notice of cancellation of this type of binder within 45 days after the date the binder was given.
- Establishes separate provisions governing the current notice requirements for cancellations and nonrenewals for personal and commercial insurance and excludes the following:
 - (1) personal and commercial policies subject to the bill's 45-day underwriting period;
 - (2) commercial insurance policies issued to exempt commercial policyholders if their policies provide for at least a 30-day written notice period.
- Changes references to a "certificate of mailing" to say "certificate of mail."

Commercial Insurance

- Defines commercial insurance to mean property insurance or casualty insurance issued to an individual, a sole proprietor, partnership, corporation, limited liability company, or similar entity and intended to insure against loss arising from the business pursuits of the insured entity.
 - Excludes from the definition (1) policies issued by the Maryland Automobile Insurance Fund, (2) policies issued by the Joint Insurance Association, (3) workers' compensation insurance, or (4) title insurance.
- Requires an insurer of commercial insurance to send to the insured, at least 45 days prior to the date of a proposed cancellation or expiration of a policy, written notification of intention to cancel for a reason other than nonpayment of premium or notice of intention not to renew a policy issued in Maryland.
 - Requires the insurer to maintain proof of mailing for this notice in a form authorized or accepted by the U.S. Postal Service or other commercial mail delivery service.
 - Deems a notice given to the insured by an insurance producer on behalf of the insurer to have been given by the insurer.
 - Provides that no notice is required if the insured has replaced the insurance.
 - Requires the insurer to provide to the named insured a written statement of the actual reason for the cancellation or refusal to renew. The actual reason must be clear and specific.
- Requires the insurer to include in the statement an offer to provide additional information upon written request of the insured and an address for the insured to submit a request.
 - Requires the insured to send the written request for more information no more than 30 days from the date of the notice containing the actual reason.
 - Requires the insurer to respond in writing to a written request by an insured for additional information within 15 days from receipt. Provides that a request for additional information does not stay the proposed action except with respect to § 27-501.
- Prohibits the Insurance Commissioner from disallowing a proposed action of an insurer because the statement of actual reason contains any one of the following:
 - (1) grammatical, typographical, or other errors, if the errors are not material to the proposed action and are not misleading;

- (2) surplus information, if the surplus information is not misleading; or
 - (3) erroneous information, if in the absence of the erroneous information there is a sufficient basis to support the proposed action.
- Provides that the information concerning the actual reason is privileged and does not constitute grounds for an action against the insurer, the insurer's representative, an insurance producer, or any other person that in good faith provides information on which the statement is based.
 - Requires an insurer to provide written notification to an insured, whenever the insurer gives notice of its intention to cancel or nonrenew a policy for a reason other than nonpayment of premium, of the possible right to replace the insurance under the Maryland Property Insurance Availability Act, through the Maryland Automobile Insurance Fund, or through another plan for which the insured may be eligible.
 - Requires the notice, if applicable, to include the current address and telephone number of the offices of the Joint Insurance Association, the Maryland Automobile Insurance Fund, or other appropriate plan.
 - Requires the notice to be sent to the insured in the same manner and at the same time as the first written notice of cancellation or of intention not to renew as required by law, regulation, or contract.
 - Requires an insurer, at least 10 days before the date the insurer proposes to cancel a policy for nonpayment of premium, to send to the insured, by certificate of mail, a written notice of intention to cancel for nonpayment of premium.
 - Allows an insurer to terminate a policy on the renewal date, if the insurer provides a renewal policy and notice of the premium due at least 45 days before the renewal date of the policy and the insured fails to pay on time.
 - Requires the insurer to provide at least 10 days, in an offer to reinstate the policy, for the insured to make the required premium payment.
 - Retains current notice requirements for commercial insurance for premium increases of 20% or more and specifies that the statement include the amounts of the renewal and expiring premium as well as contact information where the insured can get additional information. If an insurer's rating methodology requires the insured to provide information to calculate the renewal premium, the insurer must provide a reasonable estimate of that premium if the insurer has requested but has not received the required information from the insured.
 - Specifies criteria for basing the estimate and for mailing the required notice.

- Provides the option of excluding increases resulting from the following occurrences in determining the amount of a premium increase:
 - (1) an increase in the units of exposure;
 - (2) the application of an experience rating plan;
 - (3) the application of a retrospective rating plan;
 - (4) a change made by the insured that increases the insurer's exposure;
or
 - (5) an audit of the insured.
- Requires the notice to be sent by first-class mail and may be sent together with the renewal policy.

Personal Insurance

- Defines personal insurance to mean property insurance or casualty insurance issued to an individual, trust, estate, or similar entity that is intended to insure against loss arising principally from the personal, noncommercial activities of the insured.
 - Excludes from the definition (1) motor vehicle liability insurance policies subject to § 27-613, (2) policies issued by the Maryland Automobile Insurance Fund, (3) policies issued by the Joint Insurance Association, or (4) surety insurance.
- An insurer for personal lines insurance must maintain proof of mailing, in a form authorized or accepted by the U.S. Postal Service, of the notice of intention to cancel for a reason other than nonpayment of premium, or of the notice of intention not to renew a policy issued in the State.
- Modifies that the required statement of the actual reason for cancellation or refusal to renew a policy be sent to the named insured, not the applicant.
 - Repeals the limitation that the statement applies only to binders that have been in effect for at least 15 days.
- Repeals the requirement that the statement be sufficiently clear and specific so that a person of reasonable intelligence could identify the basis of the decision without making further inquiry. Requires the statement to be clear and specific.
- Prohibits the Insurance Commissioner from disallowing an insurer's proposed action because the statement contains any one of the following:

- (1) nonmaterial and non-misleading grammatical, typographical, or other errors;
 - (2) non-misleading surplus information;
 - (3) erroneous information, if in its absence there is a sufficient basis to support the action.
- Requires an insurer to send, at least 45 days prior to the renewal date of a policy, a notice to the named insured and the insurance producer, if any, by first-class mail stating both the amount of the renewal policy premium and the amount of the expiring policy premium.
 - Changes the current 17-day notice requirement for renewal notices to 45 days and restricts the requirement to personal insurance and private passenger motor vehicle liability insurance.
 - Repeals the requirement that an insurer selling personal insurance and policies in the residual market send a specific notice to the insured and the insurance producer for premium increases of 20% or more.
 - Requires insurers to send a notice to the insured and the insurance producer stating both the amounts of the renewal and expiring premium instead.

Effective date: January 1, 2007

HOUSE BILL 760 (Chapter 350) - Insurance - Private Passenger Motor Vehicle Liability Insurance - Cancellations, Failures to Renew, Reductions in Coverage, and Premium Increases

- Separates existing provisions applicable to private passenger motor vehicle liability insurance for (1) cancellations, nonrenewals, and reductions in coverage; and (2) premium increases into separate sections of the Insurance Article, with some amendments.
- Changes all references from “certificate of mailing” to “certificate of mail.”

Cancellations, Nonrenewals, and Reductions in Coverage

- Clarifies that an insurer’s ability to cancel, nonrenew or reduce coverage in § 27-605 applies to a private passenger motor vehicle liability insurance policy or a binder of private passenger motor vehicle liability insurance, if the binder has been in effect for at least 45 days.

- Modifies the disclosure requirements of an insurer proposing to cancel, nonrenew or reduce coverage for policies or binders subject to this section in the following ways:
 - Repeals disclosure requirements if a proposed action is based wholly or partly on a credit score or information from a credit report.
 - Repeals the requirement that an insurer's statement of actual reason for proposing to take an action be sufficiently clear and specific so that an individual of average intelligence can identify the basis for the insurer's decision without making further inquiry.
 - Requires an insurer's statement of actual reason for proposing to take an action subject to this section to be clear and specific and include a brief statement of the basis for the action, including, at a minimum the following:
 - (1) If the action of the insurer is due wholly or partly to an accident:
 - (a) the name of the driver;
 - (b) the date of the accident; and
 - (c) if fault is a material factor for the insurer's action, a statement that the driver was at fault;
 - (2) If the action of the insurer is due wholly or partly to a violation of the Maryland vehicle law or the vehicle laws of another state or territory of the United States:
 - (a) the name of the driver;
 - (b) the date of the violation; and
 - (c) a description of the violation;
 - (3) If the action of the insurer is due wholly or partly to the claims history of an insured, a description of each claim;
 - (4) Whether the insurer's action is based on a violation of law, policy terms or conditions, or the insurer's underwriting standards;
 - (5) Whether the insurer's action is based on a material misrepresentation; and
 - (6) Any other information that is the basis for the insurer's action.
- Adds that the Insurance Commissioner may not disallow a proposed action of an insurer because the statement of actual reason contains erroneous information, provided that in the absence of the erroneous information, there remains a sufficient basis to support the action.

- Provides that at a hearing regarding a protest filed by or on behalf of the insured over an insurer's proposed action, the insurer has the burden of proving its proposed action is in accordance with insurer's filed rating plan, its underwriting standards, or the lawful terms and conditions of the policy related to a cancellation, nonrenewal, or reduction in coverage, as applicable, and not in violation of the discrimination in underwriting section of the law.

Premium Increases

- Creates a new section of the Insurance Article that applies only to premium increases for private passenger motor vehicle liability insurance.
- Provides that § 27-605.1 does not apply to the Maryland Automobile Insurance Fund.
- Provides that an "increase in premium" and "premium increase" include an increase in total premium for a policy due to (1) a surcharge, (2) retiering or other reclassification of an insured, or (3) removal or reduction of a discount.
- Requires an insurer, at least 45 days before the effective date of an increase in the total premium for a policy, to send written notice of the premium increase to the insured at the last known address of the insured by certificate of mail.
 - Provides that the notice need not be given if the premium increase is part of a general increase in premiums that is filed in accordance with insurance rating provisions of the Insurance Article and does not result from a reclassification of the insured.
 - Allows an insurer to send the notice with or be included in the renewal offer or policy.
 - Requires the notice to be sent in duplicate and on a form approved by the Insurance Commissioner.
 - Provides that the notice state in clear and specific terms:
 - (1) The premium for the current policy period;
 - (2) The premium for the renewal policy period;
 - (3) The basis for the action, including, at a minimum:
 - (a) If the premium increase is due wholly or partly to an accident:
 1. The name of the driver;
 2. The date of the accident; and

3. If fault is a material factor for the insurer's action, a statement that the driver was at fault.
- (b) If the premium increase is due wholly or partly to a violation of the Maryland vehicle law or the vehicle laws of another state or territory of the United States:
 1. The name of the driver;
 2. The date of the violation; and
 3. A description of the violation.
- (c) If the premium increase is due wholly or partly to the claims history of an insured, a description of each claim; and
- (d) Any other information that is the basis for the insurer's action;
- (4) That the insured should contact the insured's insurance producer or insurer for a review of the premium if the insured has a question about the increase in premium or believes the information in the notice is incorrect;
- (5) The right of the insured to protest the premium increase and, in the case of a premium increase of more than 15% for the entire policy, to request a hearing before the Insurance Commissioner by mailing or transmitting by fax to the Insurance Commissioner:
 - (a) A copy of the notice;
 - (b) The insured's address and daytime telephone number; and
 - (c) A statement of the reason that the insured believes the premium increase is incorrect.
- (6) The address and fax number of the Maryland Insurance Administration; and
- (7) That the Insurance Commissioner shall order the insurer to pay reasonable attorney fees incurred by the insured for representation at a hearing if the Insurance Commissioner finds the following:
 - (a) The actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with the Insurance Article or the insurer's filed rating plan; and
 - (b) The insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.

- Allows the insured to protest a proposed premium increase within 30 days after the mailing date of the notice if the insured believes that the premium increase is incorrect.
 - The insured must mail or fax with the written protest a copy of the notice, the insured's address and daytime telephone number, and a statement of the reason that the insured believes the premium increase is incorrect.
 - Requires the Insurance Commissioner, upon receipt of a protest, to notify the insurer of the filing of the protest.
 - Provides that a protest filed by the insured with the Insurance Commissioner does not stay the proposed action of the insurer except when a premium increase for a policy exceeds 15%. In that case, the Insurance Commissioner may order a stay of the premium increase pending a final decision if he/she makes a finding that the premium increase may cause the policyholder undue harm and is in violation of the insurer's filed rating plan.
 - Requires the Insurance Commissioner, based on the information contained in the notice of protest, to determine whether the insurer's action is in accordance with the insurer's filed rating plan and the Insurance Article generally and dismiss the protest or disallow the proposed action of the insurer.
 - Requires the Insurance Commissioner to notify the insurer and the insured of the action of the Insurance Commissioner promptly in writing.
 - Allows the aggrieved party to request a hearing for a premium increase of more than 15% for the entire policy.
 - Requires that such a request be made within 30 days after the mailing date of the Insurance Commissioner's notice of action.
 - Requires the Insurance Commissioner to hold a hearing within a reasonable time after the request for a hearing is received and give written notice of the time and place of the hearing at least 10 days before the hearing.
 - Specifies that a hearing requested under § 27-605.1(d) be held in accordance with Title 10, Subtitle 2 of the State Government Article.
 - Provides that the insurer has the burden of proving its proposed action to be in accordance with its filed rating plan and the Insurance Article generally.
 - Allows the insurer to rely only on the reasons set forth in its notice to the insured.

- Requires the Insurance Commissioner to issue an order within 30 days after the conclusion of the hearing.
- Requires the Insurance Commissioner, if he/she finds the proposed action of the insurer to be in accordance with the insurer's filed rating plan and the Insurance Article, to dismiss a protest and if the insurer's action is stayed, allow the proposed action of the insurer to be taken on the latter of its proposed effective date or 30 days after the date of the determination.
- Requires the Insurance Commissioner, if he/she finds that the actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with the insurer's filed rating plan or the Insurance Article, to disallow the action and order the insurer to pay reasonable attorney fees incurred by the insured for representation at the hearing if the Insurance Commissioner finds that the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.
- Prohibits the Insurance Commissioner from dismissing a protest solely because of the insured's failure to state a reason that the insured believes the premium increase is incorrect.
- Requires an insurer, if the Insurance Commissioner disallows a premium increase for the entire policy, to return to the insured all disallowed premium received from the insured, and pay to the insured interest on the disallowed premium received from the insured at 10% a year from the date the disallowed premium was received to the date it was returned.
 - Requires an insurer, if it fails to return any disallowed premium and interest to the insured as provided within 30 days after the Insurance Commissioner disallows the action of the insurer, to pay interest on the disallowed premium at 20% a year beginning on the 31st day following the disallowance to the date the disallowed premium is returned.
 - Provides that if an insurer fails to return any disallowed premium or fails to pay interest to an insured as set forth in the above scenarios, the insurer is subject to penalties under § 4-113(d) of the Insurance Article.
- Allows a party to a proceeding under this section to appeal the decision of the Insurance Commissioner in accordance with § 2-215 of the Insurance Article.

Uncodified Language

- Allows the Maryland Insurance Administration to establish a pilot program for the purpose of reducing the number of protests filed with the Insurance Commissioner pertaining to private passenger motor vehicle liability insurance.
 - Makes participation by insurers and insureds in the pilot program voluntary.
 - Allows pilot programs to require participating insurers to provide certain information and assistance to consumers who request information about premium increases.
 - Requires the Maryland Insurance Administration, on or before January 1, 2008, to report to the Senate Finance Committee and the House Economic Matters Committee, on the implementation and results of the pilot program.

Effective date: January 1, 2007 (Applies to all private passenger motor vehicle liability binders and policies issued or renewed on or after 1/1/07)

HOUSE BILL 956 (Chapter 594) - Insurance - Waiver of Customer Liability - Utility Providers

- Provides that a waiver of customer liability is not considered insurance under the Insurance Article.
- A waiver of customer liability is defined to mean an optional agreement between a utility provider and a customer of the utility provider under which the utility provider agrees, in return for a specified charge payable by the customer to the utility provider, to waive all or part of the customer's liability to the utility provider for incurred charges during a defined period in the event of any of specified qualifying events.
- The qualifying events or conditions are as follows:
 - (1) call to active military service;
 - (2) involuntary unemployment;
 - (3) death;
 - (4) disability;
 - (5) hospitalization;
 - (6) marriage;
 - (7) divorce;
 - (8) evacuation;
 - (9) displacement due to natural disaster or other cause;
 - (10) qualification for family leave; or
 - (11) any other similar event or condition.

- Utility provider is defined as (1) a public or private provider of electricity, gas, water, wastewater, solid waste collection, or similar service; or (2) a provider of communications services involving the transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals to a point or between or among points by or through any medium or method. The term includes cable service, internet access service, voice over internet service, telephone or wireless telephone service, and other similar providers.

Effective date: October 1, 2006

HOUSE BILL 1261 (Chapter 388) - Homeowner's Insurance - Summary of Coverage, Notice Regarding Flood Insurance, and Statement of Additional Optional Coverage

- Requires an insurer to provide a policyholder with an annual statement that summarizes the coverages and exclusions under a homeowner's insurance policy issued by the insurer.
 - Insurer is defined to mean an insurer that issues or delivers a policy of homeowner's insurance in the State.
 - Requires the statement to be clear and specific and state whether the coverages under the policy provide for replacement cost, actual cash value, or other method of loss payment for covered structures and contents.
 - Requires the statement to include a disclosure that states the following:
 - (1) The policyholder should read the policy for complete information on coverages and exclusions;
 - (2) The policyholder should refer to the declarations page for a listing of the coverages purchased;
 - (3) The policyholder should communicate with the insurance producer or the insurer for any additional information regarding the scope of coverages in the policy;
 - (4) The statement does not include additional optional coverage purchased by the policyholder, if any;
 - (5) The statement is not part of the policy or contract of insurance and does not create a private right of action;

- (6) All rights, duties, and obligations are controlled by the policy and contract of insurance; and
- (7) The standard homeowner's insurance policy does not cover losses from flood.
 - Makes clear that the statement is not part of the policy or contract of insurance and does not create a private right of action.
 - Allows the Insurance Commissioner to adopt regulations to implement the provisions relating to the required statement.
- Requires an insurer or an insurance producer that sells or negotiates homeowner's insurance to provide an applicant, at the time a policy of homeowner's insurance is initially purchased, with a written notice that states that a standard homeowner's insurance policy does not cover losses from flood.
 - Provides that the notice shall:
 - (1) state that flood insurance may be available through the National Flood Insurance Program ("NFIP") or other sources;
 - (2) provide the applicant with the contact information for the NFIP;
 - (3) advise the applicant to confirm the need for flood insurance with the NFIP or the applicant's mortgage lender;
 - (4) advise the applicant to contact the NFIP, the applicant's insurer, or the applicant's insurance producer for information about flood insurance;
 - (5) advise the applicant that flood insurance may be available for covered structures and their contents;
 - (6) advise the applicant that a claim under a flood insurance policy may be adjusted and paid on a different basis than a claim under a homeowner's insurance policy; and
 - (7) advise the applicant that a separate application must be completed to purchase flood insurance.
 - Deems an insurer or insurance producer compliant with this notice requirement if:
 - (1) within 7 days after the date of application made by telephone, the insurer or insurance producer sends by certificate of mailing the notice to the applicant or insured; and

- (2) prior to the submission of an application made using the internet, the insurer or insurance producer provides the notice to the applicant.
 - Allows the notice to be sent with the statement required under § 19-207 pertaining to additional optional coverages.
 - Provides that this notice does not create a private right of action.
- Requires an insurer or an insurance producer that sells or negotiates homeowner's insurance in the state to provide an applicant, at the time of application for homeowner's insurance, a written statement that lists all additional optional coverage available from the insurer to the applicant.
 - Additional optional coverage is defined to mean a coverage or service that covers the structures, contents, property, or activities on property that is available for purchase in connection with a standard homeowner's insurance policy.
 - Sets forth the same requirements for sending the notice as set forth above for applications made by the telephone or made using the internet.
 - Requires the statement to be on a separate form and be titled, in at least 12 point type, "Additional Optional Coverage Not Included in the Standard Homeowner's Insurance Policy."
 - Also requires the statement to contain the following disclosure in at least 10 point type:

"Your standard homeowner's insurance policy does not cover all risks. You may need to obtain additional insurance to cover loss or damage to your home, property, and the contents of your home or to cover risks related to business or personal activities on your property.

This statement provides a list of the types of additional insurance coverage that are available. Contact your insurance company, insurance producer, or insurance agent to discuss these additional coverages."

Effective date: January 1, 2007 (Applies to all personal lines homeowner's insurance policies and contracts issued, delivered, or renewed on or after 1/1/07)

HOUSE BILL 1288 (Chapter 615) - Credit Regulation - Loans Secured by Real Property - Insurance Coverage Requirements

- Clarifies that a lender may not require a borrower, as a condition to receiving or maintaining a loan secured by a first mortgage, first deed of trust, or secondary mortgage loan, to provide or purchase property insurance coverage against risks to any improvements on any real property in an amount greater than the replacement cost of the improvements on the real property.
- Clarifies that a lender may not require a borrower, as a condition to receiving or maintaining a loan secured by a first mortgage or first deed of trust, to provide or purchase flood insurance coverage in an amount greater than the replacement cost of the improvements on the real property.
- Clarifies that a creditor grantor may not require a borrower, as a condition to receiving or maintaining a loan secured by a lien, to provide or purchase property insurance coverage against risks to any improvements on any real property in an amount greater than the replacement cost of the improvements on the real property.
- Replacement cost is defined as “the amount needed to repair damage to or rebuild improvements on real property to restore the improvements to their pre-loss condition.” It does not include the value of the land.
- Improvements are defined as “buildings or structures erected upon or affixed to real property that enhance the value of the real property.”

Effective date: October 1, 2006

HOUSE BILL 1387 (Chapter 393) - Personal Insurance - Premiums - Notice

- Requires an insurer of personal insurance and insurance issued under the Maryland Property Insurance Availability Act or any similar act instituted to ensure the availability of property insurance to send, at least 45 days prior to the renewal date of a policy, a notice to the named insured and the insurance producer, if any, by first-class mail stating both the amount of the renewal policy premium and the amount of the expiring policy premium.
 - HB 1387 moves the substance of § 27-601, unchanged, to a new § 27-601.1. However, HB 570 amends the substance of § 27-601 and then inserts it into two sections - one section pertaining to “personal insurance” (§ 27-602) and another section pertaining to “commercial insurance” (§ 27-603). The provisions of HB 570 will control as HB 570 became law after HB 1387, superseding the provisions of HB 1387.

- Defines personal insurance to mean property insurance or casualty insurance issued to an individual, trust, estate, or similar entity that is intended to insure against loss arising principally from the personal, noncommercial activities of the insured.
 - Excluded from the definition are:
 - (1) motor vehicle liability insurance policies subject to § 27-605;
 - (2) policies issued by the Maryland Automobile Insurance Fund;
 - (3) policies issued by the Joint Insurance Association; or
 - (4) surety insurance.
 - Both HB 1387 and HB 570 have a "Definition Section" numbered § 27-601. The definition of "personal insurance" added to § 27-601 by both of these Bills is identical; however, HB 570 also adds a definition of "commercial insurance" to § 27-601 while HB 1387 does not. The provisions of HB 570 will control as HB 570 became law after HB 1387, superseding the provisions of HB 1387.

Effective date: January 1, 2007

HOUSE BILL 1600 (Chapter 410) - Insurance - Automobile Insurance and Prosecution of Automobile Theft

- Requires the Insurance Fraud Division, if appropriate after an investigation, to assist local and state law enforcement agencies in the prosecution of automobile theft.
- Requires insurers that use territories as a factor in establishing automobile insurance rates to submit a statement to the Insurance Commissioner certifying that (1) the territories used by the insurer have been reviewed within the previous three years and (2) the use of the territories is actuarially justified.
- Requires the Insurance Commissioner, on or before July 1 of each year, to submit a report to the General Assembly about the use of territory as a factor in establishing private passenger automobile insurance rates by insurers and the Maryland Automobile Insurance Fund.
 - Provides that the report shall contain information on (1) the number of insurers actively engaged in providing private passenger automobile insurance coverage in the State and (2) the number of insurers that use territory as a factor in establishing private passenger automobile insurance rates.

Effective date: October 1, 2006

MISCELLANEOUS

HOUSE BILL 165 (Chapter 79) - Insurance - Examination Reports

- Requires an examinee to present the report of a financial examination or a market conduct examination to the examinee's Board of Directors at the next regularly scheduled Board meeting.
- Adopts clarifying language pertaining to what the Insurance Commissioner must do before adopting a proposed examination report, when the Insurance Commissioner may adopt certain reports if a hearing has been requested, when certain reports are admissible as evidence, and when certain individuals may testify regarding certain reports. This language conforms to recent changes made by the National Association of Insurance Commissioners ("NAIC") in an effort to clear up ambiguities in the current language and does not represent a change in current process or procedure.
- Clarifies that adopted reports are considered public documents and may be disclosed to the public.

Effective date: October 1, 2006

HOUSE BILL 245 (Chapter 564) - Insurance - Prior Approval Rating Law - Exempt Policyholders

- Lowers the annual threshold that a person must pay in annual aggregate property and casualty premiums for commercial policies, to \$25,000, in order to qualify as an exempt commercial policyholder under the State's prior approval rate making law.
- Maintains other existing requirements needed to be met to receive the exempt commercial policyholder status.

Effective date: October 1, 2006

HOUSE BILL 246 (Chapter 83) - Temporary Insurance Producer Licenses - Specified Types of Insurance

- Eliminates the ability to obtain a temporary insurance producer license to sell property insurance, casualty insurance, life insurance, or health insurance.

Effective date: October 1, 2006

HOUSE BILL 583 (Chapter 581) - Surplus Lines Insurance - Compliance with Filing Requirements - Electronic Transmission

- Provides that a surplus lines insurer may file a required report, affidavit, or return electronically on or before the filing date in a manner approved by the Insurance Commissioner.

Effective date: October 1, 2006

HOUSE BILL 597 (Chapter 182) - Insurance - Prohibited Acts - Inducements to Financing an Insurance Contract

- Prohibits an insurance producer, employee of an insurance producer, or any other person from accepting, directly or indirectly, any valuable consideration as an inducement to facilitate a premium finance agreement.

Effective date: October 1, 2006

HOUSE BILL 739 (Chapter 349) - Insurance - Improper Premiums and Charges - Bail Bonds - Penalty

- Subjects a person who violates the prohibition against charging improper premiums for bail bonds to a penalty of up to \$5,000 per offense.
 - This penalty is in addition to any other applicable sanction permitted by law.

Effective date: October 1, 2006

HOUSE BILL 833 (Chapter 586) - Surety Insurance - Failure to Pay Bail Bond Judgment - Penalties

- Clarifies that a surety insurer is subject to the penalties under § 4-113 of the Insurance Article when the insurer is removed by the District Court from the Court's list of surety insurers eligible to post bonds with the Court because the insurer failed to timely resolve or satisfy one or more bail bond forfeitures appearing on the District Court's list of absolute bond forfeitures in default.
- Requires that, within 14 days after a surety insurer fails to resolve or satisfy all bond forfeitures within the District Court's deadline, the District Court must notify the Commissioner, in writing, of the insurer's name and of each forfeiture that was not resolved by the deadline.

Effective date: October 1, 2006

HOUSE BILL 861 (Chapter 194) - Insurance - Regulation of Premium Finance Companies

- Increases the application fee, from \$50 to \$250, a premium finance company pays upon initial registration with the Maryland Insurance Administration.
- Requires a premium finance company to file with the Insurance Commissioner, in addition to the initial application, the following items:
 - (1) in the case of a corporation or limited liability company, a certificate of good standing issued by the State Department of Assessments and Taxation;
 - (2) evidence of compliance with § 23-202 financial requirements;
 - (3) the form of the premium finance agreement to be used; and
 - (4) the finance charge, initial service fee, and all other fees and charges to be applied.
- Requires a premium finance company to file with the Insurance Commissioner, at renewal, the following items:
 - (1) a renewal application on the form that the Insurance Commissioner requires;
 - (2) in the case of a corporation or limited liability company, a certificate of good standing issued by the State Department of Assessments and Taxation; and
 - (3) evidence of compliance with the financial requirements set forth in § 23-202.
- Retains the current renewal fee of \$50.
- Requires a premium finance company to report any changes in its officers, directors, owners, trade names, principals, partners, business addresses, and telephone numbers within 30 days after any such change occurs.
- Requires a premium finance company to file and receive the Insurance Commissioner's approval on any change to the form of its premium finance agreements, the finance charge, initial service fee, and any other fees and charges before using the new finance agreements or applying new fees or charges.
- Requires a premium finance company to disclose to the Insurance Commissioner, upon written request, the method or formula used to calculate the finance charges and amount of refund on cancellation of the insurance contract.

- Increases the maximum penalty the Insurance Commissioner may impose upon a premium finance company from \$500 per violation with a cap of \$1,000 to \$1,000 per violation with a maximum of \$20,000.
- Clarifies that a premium finance company is responsible for a violation of the Premium Financing Title of the Insurance Article in the administration of the premium finance agreement by a delegated third party.
 - Excludes the following acts by an insurance producer in relation to a premium finance agreement from the administration of a premium finance agreement:
 - (1) signing a premium finance agreement;
 - (2) accepting payments; or
 - (3) issuing receipts.
- Removes a requirement that the premium finance agreement contain a prefix. Provides that the application number or binder number listed on a finance agreement is sufficient if a policy number has not been created at contract formation.
- Allows a premium finance company to send any notices required under the law in a number of different ways, including electronically, at the option of the insured. These methods of notification were previously limited to commercial automobile, fire, or liability insurance.
- Provides that a notice delivery method other than personal delivery, first class mail, or commercial delivery service may be used only with the written consent of the insured.
- Clarifies that the cancellation of an insurance contract on the date stated in a notice of intent to cancel or a notice of cancellation is not superseded by a premium finance company's issuance of a subsequent notice of intent to cancel or a notice of cancellation.
- Gives an insurance producer and a premium finance company 15 business days from the date of written notice from a financial institution that a check has been dishonored to notify an insurer to render the insurance contract invalid and the insurance policy void.
- Makes changes to the disclosure required, in connection with the sale of personal lines automobile insurance, by an independent insurance producer, who directly or indirectly has an ownership interest in a premium finance company. The producer must send to an insured a disclosure that compares the costs and terms of premium financing with the insurer's alternative payment plan. The disclosure must state the total amount to be paid by the insured under the premium finance agreement compared to an insurer's alternative plan during the policy term. This added

disclosure must also include the premium, any down payment, and all interest, fees and charges resulting from the agreement and any extension of credit under both the premium finance agreement and the insurer's alternate plan.

Effective date: October 1, 2006

HOUSE BILL 1460 (Chapter 620) - Title Insurers and Title Insurance Producers

- Allows a title insurance producer to use or accept the services of a title insurance producer independent contractor only if the title insurance producer independent contractor holds an appointment with the title insurer with which the contract of title insurance may be placed.
 - A title insurance producer independent contractor is defined to mean a person that (1) is licensed to act as a title insurance producer; (2) provides escrow, closing, or settlement services that may result in the issuance of a title insurance contract as an independent contractor for, or on behalf of, a licensed and appointed title insurance producer; and (3) is not an employee of, or associated with, the licensed and appointed title insurance producer.
- Requires an applicant for a license as a title insurance producer to file a blanket fidelity bond covering title insurance producer independent contractors in addition to the already required bond covering appropriate employees.
 - Specifies that the bonding requirements relating to title insurance producers do not apply to an employee or officer of an authorized title insurer.
- Modifies the required annual on-site review of each title insurance producer appointed by the title insurer as a principal agent. A title insurer is required to perform an on-site review of appointed principal agents each calendar year, with one exception. The insurer is not required to perform the review for the calendar year during which the title insurance producer is initially appointed if the appointment is made on or after June 30 of that calendar year.
- Subjects a title insurer's written report regarding an on-site review of a title insurance producer to a full market conduct examination, not merely a financial examination.
- Clarifies the circumstances under which title insurers are required to inform the Commissioner of suspected violations by the title insurance producer. Title insurers are now required to report a producer who has engaged in activities prohibited by § 10-126 of the Insurance Article.
- Requires a title insurance producer to notify any title insurer with whom the title insurance producer holds an appointment whenever a licensed person becomes employed by, or associated with, the title insurance producer.

- Provides that all licensing provisions of the subtitle pertaining to insurance producers apply to an attorney who solicits, procures, or negotiates title insurance contracts and title agencies even if the title agency is established by an association of attorneys.
 - Defines attorney as an individual admitted to practice law by the Court of Appeals of the State.
- Provides that the licensing, bonding, education, experience, and examination requirements for title insurance producers do not apply to law firms.
 - Defines law firm to mean an association of attorneys in a law partnership, professional corporation, sole proprietorship, or other business entity who are primarily engaged in the practice of law and solicit, procure, or negotiate title insurance contracts only as an incident to the practice of law.
 - Modifies the definition of title agency to exclude a law firm.
- Provides that the education, experience, and examination requirements relating to title insurance producers do not apply to attorneys.
- Provides that the bonding requirements relating to title insurance producers apply to (1) an attorney or an association of attorneys who own, operate, or share an interest in a title agency and (2) an attorney who is employed by a title agency as a title insurance producer.
- Gives the Insurance Commissioner discretion to issue a limited lines license to an attorney licensed in Maryland who solicits, procures, or negotiates title insurance contracts to act as a title insurance producer.
- Changes requirements relating to notice that is given to consumers in connection with a real estate transaction that involves a purchase money mortgage or deed of trust on land in the State, by the person first accepting a title insurance premium or mortgage title insurance. This bill repeals the requirement that the title insurer maintain a statement of receipt of the notice for 3 years. Now, the person giving the notice is required to retain the statement of receipt. In addition, the consumer notification requirements do not apply to real estate transactions involving a mortgage or deed of trust securing an extension of credit made (1) solely to acquire an interest in or to carry on a business or commercial enterprise or (2) to any business or commercial organization.

Effective date: October 1, 2006

SB 251 (Chapter 514) - Insurance - Loans and Advances Made to Stock Insurers and Mutual Insurers

- Removes the interest rate cap of six percent that a director, officer, or member of a stock insurer may collect on a loan or advance to that stock insurer.
- Treats loans and advances made to stock insurers and mutual insurers equally.
- Provides that the instrument evidencing a loan or advance be approved as to both form and content by the Insurance Commissioner.
- Requires the instrument evidencing a loan or advance to specify that the instrument is subordinate to policyholders, claimant and beneficiary claims, and all other classes of creditors other than surplus note holders.
- Requires the instrument evidencing a loan or advance to specify that interest payments and principal repayments may not be made without prior approval of the Insurance Commissioner.
- Requires proceeds of a loan or advance made to stock insurers or mutual insurers be in the form of cash or other admitted assets having readily determinable values and liquidity that meet the satisfaction of the Insurance Commissioner.
- Repeals the requirement that a loan or advance made to a stock insurer or mutual insurer under a notice of deficiency made by the Insurance Commissioner be repaid or withdrawn only with the express written consent of the Insurance Commissioner.

Effective date: October 1, 2006