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BULLETIN 13-27

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 2013 Insurance Legislation Signed into Law by Governor Martin O'Malley**

Date: **August 19, 2013**

This summary is meant to place insurers, nonprofit health service plans, health maintenance organizations, dental plan organizations, pharmacy benefits managers, and producers (regulated entities) authorized to do business in Maryland on notice of certain laws passed during the 2013 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 law, 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 2013 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 2013 Session by accessing the Maryland General Assembly's web site at http://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 2013 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 2013 insurance legislation, please contact Tinna Damaso Quigley at (410) 468-2202 or tinna.quigley@maryland.gov.

2013 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 228 (Chapter 159) – Maryland Health Progress Act of 2013

Medicaid Expansion

- Expands Medicaid eligibility, effective January 1, 2014, to children ages 6 through 18 and adults younger than age 65 with family or household incomes up to 133% of Federal Poverty Guidelines and former foster care adolescents up to age 26.

Maryland Health Benefit Exchange Financing

- Establishes a dedicated funding stream for the Maryland Health Benefit Exchange (MHBE) from insurance premium tax on insurers excluding managed care organizations (MCOs) and for-profit health maintenance organizations (HMOs).

- Beginning January 1, 2015, an amount must be distributed annually to the MHBE Fund that is sufficient to fully fund the operation and administration of MHBE.

- In fiscal 2015, the Governor must provide an annual appropriation in the State budget for MHBE of no less than $10 million.

- Annually thereafter, the appropriation must be no less than $35 million. Any unspent funds revert to the general fund at the end of each fiscal year.

Maryland Health Insurance Plan Transition

- Provides for the transition of Maryland Health Insurance Plan (MHIP) enrollees into MHBE. Requires that enrollment in MHIP be closed as of December 31, 2013. Requires the MHIP Board in consultation with MHBE to determine the appropriate date on which the plan must decline to reenroll existing plan members. The date must be no earlier than January 1, 2014 and no later than January 1, 2020.

State Reinsurance Program

- Provides funding for the establishment and operation of a State Reinsurance Program to mitigate the impact of excessive healthcare expenses incurred by high-risk individuals on rates in the individual insurance market inside and outside of the MHBE. To fund the program, the legislation authorizes the use of the hospital assessment that currently funds MHIP.

Continuity of Care

- Effective January 1, 2015, establishes policies to promote continuity of care for individuals who switch private insurance coverages or move out of Medicaid and into private insurance coverage.

- Requires generally a receiving carrier or managed care organization (MCO) to accept preauthorization from a relinquishing carrier, MCO, or third-party administrator for provision of covered services for certain conditions for specified time periods.

- Requires generally carriers and MCOs to allow a new enrollee to continue to receive health care services being rendered by a nonparticipating health care provider for these conditions for specified periods.

- Requires the receiving carrier or MCO to pay the nonparticipating provider the rate, and to use the method of payment, the carrier or MCO normally would pay and use for similar participating providers.

Other Provisions

- Establishes a new definition of small employer to comply with the Patient Protection and Affordable Care Act (ACA).

- Establishes a consolidated services center which may employ individuals to assist the Small Business Health Options Program (SHOP) Exchange or the Individual Exchange.

- Authorizes captive producers of a carrier to transition that carrier's existing enrollees into a qualified plan of that carrier's in the Exchange and to provide enrollment assistance for individuals who contact the carrier.

- Permits MHBE to designate community-based organizations, health care providers, and other entities as application counselors.

- Establishes certification requirements and an appeals process for qualified health plans.

- Specifies rules for small employer premium contributions made on behalf of employees.

- Authorizes MHBE to establish requirements relating to qualified vision and dental plans.

- Establishes study and reporting requirements relating to continuity of care policies, tobacco use rating, the captive producer program, and pediatric dental benefits.

- Provides MHBE authority to deny, suspend, or revoke certification of a qualified health plan and to impose a penalty not exceeding $5,000 for violation of or failure to comply with standards for certification.

Effective Date: ***June 1, 2013***

HOUSE BILL 360 (Chapter 106) – <u>Health Insurance - Repeal of Obsolete Provisions of Law</u>

- Repeals provisions of insurance law that are obsolete under the ACA or other federal or state law. The following provisions were repealed:

    - Insurance Article §15-410, Continuation Coverage upon Death of Group Member, which authorized a group health insurance policy to provide for continuation of benefits after the death of an individual in the insured group.

    - Health General Article §19-703(e), Limited Benefit Plans Offered by HMOs, which authorized HMOs to offer limited benefit plans that met the requirements of former Art. 48A, § 490-O.

    - Insurance Article §15-412, Conversion of Coverage, which required insurers and nonprofit health service plans to offer an individual health insurance policy to each group member whose group health insurance coverage terminated.

    - Insurance Article §15-415, Notice to Employer of Coverage Under Succeeding Policy, which required a succeeding insurer to provide the employer information about waiting periods for preexisting conditions, exclusions, or similar policy provisions that exclude coverage for group members.

    - Insurance Article §15-504, Effect of Breast Implants on Coverage, which provided that an insurer or nonprofit health service plan could not deny coverage or non-renew coverage because an individual has had a breast implant.

    - Insurance Article §15-507, Coverage for Preexisting Conditions, which required coverage for preexisting conditions under a group policy if an individual in the group had prior coverage.

    - Insurance Article §15-110, Catastrophic Health Insurance Policies, which required nonprofit health service plans to offer a catastrophic health insurance policy that could have a deductible equal to the basic health insurance coverage or major medical insurance of the insured, with a limit of $1,000,000.

Effective Date: ***January 1, 2014***

HOUSE BILL 361 (Chapter 368) – Health Insurance - Conformity with and Implementation of Federal Patient Protection and Affordable Care Act

Shop Exchange Navigators

- Establishes license, biennial renewal, and reinstatement fees for SHOP Exchange navigators.
- Authorizes the Insurance Commissioner (Commissioner) to deny a SHOP Exchange navigator license after notice and an opportunity for a hearing.

Expansion of Commissioner's Authority to Enforce Certain ACA Provisions

- Expands the Commissioner's authority to enforce certain specified ACA requirements such as annual limits on cost sharing, child-only plan offerings in the individual market, minimum benefit requirements for catastrophic plans, health insurance premium rates, coverage for individuals participating in clinical trials, contract requirements for stand-alone dental plans sold on the Exchange, and the annual limit on deductibles for small employer plans.

Preexisting Condition Exclusions

- Specifies that carriers may impose a preexisting condition provision, under specified circumstances, only for plan years that begin prior to January 1, 2014, and for individual health benefit policies that are issued or delivered prior to January 1, 2014.

Comprehensive Standard Health Benefit Plan

- Repeals the requirement that the Commissioner transmit certain information to the Maryland Health Care Commission (MHCC) to use in determining the benefits under the Comprehensive Standard Health Benefit Plan, because MHCC will no longer be determining the benefits for new plans issued in the small employer market.

Wellness Programs

- Amends § 15-509 of the Insurance Article to permit higher incentives for participation in certain wellness programs consistent with federal regulations**.**

Association Plans

- Amends §15-1309 of the Insurance Article to be consistent with final Federal Market Rules that prohibit carriers from terminating coverage of an individual who ceases to be a member of the association or from requiring an applicant to become a member of the association to be covered under an association health benefit plan.

- Repeals § 15-1105 of the Insurance Article, which set forth disclosure requirements for insurers and nonprofit health service plans that require evidence of individual insurability for coverage under an out-of-state association contract.

Small Employers

- Adds new definitions of coverage level, dependent, employee, eligible employee, full-time employee, part-time employee, plan year, qualified employer, qualified health plan, qualifying coverage in an eligible employer-sponsored plan, SHOP Exchange, and small employer that are consistent with the definitions found in the ACA.

- Adds provisions which establish how small employees will be counted that are consistent with the ACA.

- Requires that premium rates for each small employer be set for an entire year both within and outside the Exchange consistent with requirements of the ACA.

- Requires an annual open enrollment period and special enrollment periods consistent with the ACA.

- Extends the grandfathered protection for self-employed individuals in the small employer market by removing the sunset provision.

SHOP Exchange

- Prohibits a carrier from imposing a minimum participation requirement for a qualified employer if the qualified employer designates a coverage level within which an employee may select coverage from any carrier offering that coverage level.

- Authorizes small employers to collect premiums and transmit them to the SHOP Exchange.

- Prohibits a carrier from imposing a minimum participation requirement for a small employer if the small employer group applies for coverage during a specific annual enrollment period.

Grace Periods in the Individual Exchange

- Requires an extended grace period for individuals receiving advanced payment of federal premium tax credits to pay premiums in accordance with ACA requirements.

Open Enrollment Period for Individual Market

- Establishes an initial open enrollment period for carriers that sell health benefit plans to individuals in the State from October 1, 2013, through March 31, 2014, consistent with ACA requirements.

- Beginning October 15, 2014, establishes an annual open enrollment period that begins on October 15 and extends through December 7 of each year consistent with ACA requirements.

- Adds special enrollment periods for individuals who experience certain trigger events, consistent with the ACA requirements.

Discontinuation of Individual Health Benefit Plans

- Permits carriers to cancel or refuse to renew an individual health plan that is not a grandfathered health plan under certain circumstances. The carrier may discontinue a particular plan that is not grandfathered if the carrier provides notice at least 90 days prior to discontinuation of the coverage; offers each individual the option to purchase any other individual health benefit plan offered by the carrier; and acts without regard to any health status-related factor of the enrolled individuals.

Effective Date: ***June 1, 2013***

HOUSE BILL 955 (Chapter 394) – Task Force to Study Temporary Disability Insurance Programs and the Process for Assisting Individuals with Disabilities at Local Departments of Social Services

- Establishes a task force to study benefits available under State and federal law to workers and recently unemployed individuals who are disabled due to nonwork-related illness or injury.

Effective Date: ***June 1, 2013***

HOUSE BILL 1160 (Chapter 576) / SENATE BILL 904 (Chapter 575) – Health Insurance – Vision Service - Provider Contracts

- Prohibits an insurer, nonprofit health service plan, or health maintenance organization from including a provision in a vision provider contract that requires a vision provider to provide services that are not covered services at a fee set by the carrier**,** provide discounts on materials that are not covered benefits, or participate in a capitated vision provider panel as a condition of participation in a fee-for-service vision provider panel.

- Permits a carrier to require a vision provider, as a condition of participation in a vision provider panel, to participate in an MCO.

Effective Date: ***April 1, 2014***

HOUSE BILL 1216 (Chapter 289) / SENATE BILL 581 (Chapter 288) – Health Insurance – Federal Mental Health Parity and Addiction Equity Act – Notice and Authorization Forms

- Requires each health insurer, nonprofit health service plan, and health maintenance organization (carrier) to provide on its website and annually in print to its members and insureds notice about the benefits required under the State mental health and addiction parity law and, if applicable, the Mental Health Parity and Addiction Equity Act (MHPAEA), and that the member may contact the MIA for further information about the benefits.

- Requires a carrier to post a release of information authorization form on its website and provide the form by standard mail within 10 business days after a request for the form is received.

- Requires the MIA to post a notice on its website that: (1) complaints regarding noncompliance with MHPAEA may be filed with the Commissioner; (2) an insured may obtain assistance in filing a complaint with a carrier or the MIA from the Health Education and Advocacy Unit in the Office of the Attorney General; (3) an insured may obtain a copy of his or her health insurance policy or contract and should contact the carrier for a copy; and (4) an insured may request a referral to a specialist who is not part of the carrier's provider panel under specified circumstances.

Effective Date: ***October 1, 2013***

HOUSE BILL 1252 (Chapter 291) / SENATE BILL 582 (Chapter 290) – Health Insurance – Federal Mental Health Parity and Addiction Equity Act – Utilization Review Criteria and Standards

- Applies to insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations (carriers) that propose to issue or deliver individual, group or blanket health insurance policies in Maryland that provide for utilization review of health care services.

- Requires carriers to ensure that the criteria and standards that are used in conducting utilization review for mental health and substance use benefits are in compliance with MHPAEA.

Effective Date: ***October 1, 2013***

SENATE BILL 769 (Chapter 318) – Health Benefit Plans – Proposed Rate Increases – Notice to Insureds

- Applies to insurers, nonprofit health service plans, and health maintenance organizations (carriers) that offer health benefit plans in Maryland.

- Requires each carrier to provide annual notice to insureds and enrollees and post a notice on the carrier's website that an insured or enrollee may access information about proposed rate increases for a health benefit plan and submit comments regarding the proposed rate increases on the MIA's website.

Effective Date: ***October 1, 2013***

PROPERTY AND CASUALTY

HOUSE BILL 342 (Chapter 270) / SENATE BILL 446 (Chapter 269) – Homeowner's or Renter's Insurance and Private Passenger Motor Vehicle Insurance – Bundling Requirement – Prohibited

- Prohibits an insurer from denying, refusing to renew, or canceling homeowner's insurance or renter's insurance coverage for an applicant or a policyholder solely because an applicant or policyholder does not carry private passenger motor vehicle insurance with the insurer or another insurer in the same holding company system.

- Prohibits an insurer from denying, refusing to renew, or canceling private passenger motor vehicle insurance coverage solely because the applicant or policyholder does not carry homeowner's or renter's insurance coverage with the insurer or another insurer in the same insurance holding company system.

- Does not prohibit an applicant or policyholder from bundling homeowner's insurance or renter's insurance and private passenger motor vehicle insurance policies if the applicant or policyholder desires to do so.

- Does not prohibit an insurer from offering discounts or other incentives to applicants or policyholders who choose to bundle homeowner's insurance or renter's insurance and private passenger motor vehicle insurance policies.

Effective Date: ***October 1, 2013***

HOUSE BILL 370 (Chapter 226) / SENATE BILL 313 (Chapter 225) – Workers' Compensation – Anne Arundel County Deputy Sheriff

- Specifies that an Anne Arundel County deputy sheriff is eligible for enhanced workers' compensation benefits for a permanent partial disability.

- An Anne Arundel County deputy sheriff who is awarded compensation for a period of fewer than 75 weeks for a permanent partial disability is compensated by the County at an enhanced rate that is equal to the rate for claims that are determined to be compensable for 75 to 250 weeks (two-thirds of the employee's average weekly wage, not to exceed one-third of the State average weekly wage).

Effective Date: ***October 1, 2013***

HOUSE BILL 392 (Chapter 111) – Motor Vehicle Liability Insurance – Personal Injury Protection Coverage – Prohibition on Premium Increase

- Prohibits an insurer that issues a motor vehicle liability insurance policy that contains personal injury protection (PIP) coverage from increasing the premium of a policy due to a claim or payment under the PIP coverage. Prohibited premium increases include surcharge, retiering or other classification of a policy, and the removal or reduction or a discount.

- Requires an insurer to provide written notice of this prohibition at the time the policy is issued.

Effective Date: ***October 1, 2013***

HOUSE BILL 695 (Chapter 383) – Homeowner's Insurance – Anti-Concurrent Causation Clause – Notice and Study

- Requires an insurer that issues a policy of homeowner's insurance in the State that contains an anti-concurrent causation clause (ACC) to provide a policyholder each year with a notice that: (1) is clear and specific; (2) describes the ACC clause; (3) informs the policyholder to read the policy for complete information on the exclusions; and (4) states that the insured should communicate with the insurer or the insurance producer for additional information regarding the scope of the exclusions.

- Requires the House Economic Matters Committee and the Senate Finance Committee to conduct a study on the handling by insurers and the National Flood Insurance Program of property insurance claims in cases where there are two or more factors that could affect or cause the loss.

Effective Date: ***June 1, 2013***

HOUSE BILL 1132 (Chapter 74) / SENATE BILL 749 (Chapter 73) – Maryland Automobile Insurance Fund – Operational Changes

- Decreases from 13 to 9 the number of members of the Maryland Automobile Insurance Fund (MAIF) Board of Trustees.

- Requires the Governor to appoint all 9 members of the MAIF Board with the advice and consent of the Senate.

- Requires each MAIF board member to be a resident of the State.

- Increases from 4 to 5 the number of years in a MAIF board member's term.

- Places a cap of two full terms or a total of 10 years on the amount of time a MAIF board member may serve.

- Provides that the terms of the MAIF board members are staggered.

- Alters the manner in which the MAIF Executive Director is appointed.

- Requires the MAIF Board to employ attorneys to advise and represent MAIF in all legal matters and, where necessary, to sue or defend suits in the name of MAIF; therefore, MAIF is no longer represented by the Office of the Attorney General.

- Effective October 1, 2013, removes generally MAIF employees from the State Personnel Management System. MAIF employees, however, remain State employees included in the State health and pension systems.

- Effective October 1, 2013, requires the Executive Director to appoint and remove MAIF employees in accordance with the policies of the MAIF Board.

- Repeals the authorization for the Office of Legislative Audits to conduct fiscal and compliance audits of MAIF. Instead, an audit committee, composed of members of the Board and the Executive Director, must require MAIF's internal auditor to conduct fiscal compliance and fiscal audits of the accounts and transactions of MAIF each year. A fiscal compliance audit must (1) examine financial transactions and records and internal controls; (2) evaluate compliance with applicable laws and regulations; and (3) examine electronic data processing operations.

Effective Date: ***July 1, 2013***

HOUSE BILL 1203 (Chapter 406) – <u>Homeowner's or Renter's Insurance – Policy Exclusions for Specific Breeds or Mixed Breeds of Dogs – Notices</u>

- Requires an insurer that offers a homeowner's or renter's insurance policy in the State that excludes coverage for losses caused by specific breeds or specific mixed breeds of dogs to provide written notice at the time of application or policy issuance and at each renewal.

- The written notice must state that the policy does not provide coverage for losses caused by specific breeds or specific mixed breeds of dogs and identify the specific breeds or specific mixed breeds of dogs for which the policy does not provide coverage.

Effective Date: ***October 1, 2013***

HOUSE BILL 1330 (Chapter 676) – Workers' Compensation – Insurance Coverage – Employer Compliance

- Modifies the procedures for the Workers' Compensation Commission (WCC) to enforce employer compliance with the requirements that employers secure workers' compensation insurance for their employees.

- If the WCC finds that an employer is noncompliant, it must order the employer to: (1) obtain workers' compensation insurance with any authorized insurer; (2) provide the WCC with proof of coverage; and (3) pay to the Uninsured Employers' Fund a penalty of up to $10,000.

Effective Date: ***October 1, 2013***

SENATE BILL 65 (Chapter 16) – Workers' Compensation – Claim Processing – Electronic Delivery of Decisions

- Authorizes the WCC to send copies of its decisions and orders electronically if consented to by the party's attorney of record or, if the party is unrepresented, by the party.

Effective Date: ***October 1, 2013***

SENATE BILL 505 (Chapter 487) – Criminal Procedure – Bail Bonds – Cash Bail

- Provides that if an order setting "cash bail" or "cash bond" specifies that it may be posted by the Defendant only, the "cash bail" or "cash bond" may nevertheless be posted by the Defendant, by an individual, or by a private surety, acting for the Defendant, that holds a certificate of authority in the State, except when the "cash bail" or "cash bond" is for failure to pay support under Titles 11, 12 or 13 of the Family Law Article, in which case the "cash bond" or "cash bail" may be posted by the Defendant only.

Effective Date: ***October 1, 2013***

SENATE BILL 682 (Chapter 525) – Portable Electronics Insurance – Compensation of Employees of Vendor, Disclosures to Customers, and Study

- Prohibits a portable electronics vendor or an authorized representative of the vendor from using the sale of portable electronics insurance as the sole basis for an employee's compensation.

- Requires the Commissioner to approve disclosures containing key terms and conditions of coverage under the policy rather than the major features of any exclusions, conditions, or other limitations of coverage.

- Requires the Commissioner to: (1) determine the types of limited lines insurance that are authorized to be offered in other states; (2) review the laws and practices of other states

relating to the offering of limited lines insurance; (3) review the National Association of Insurance Commissioners' guidelines and standards relating to the authorization of limited lines insurance; (4) determine the appropriate regulatory structure, including consumer protections, for the sale of a limited lines insurance policy; and (5) report any findings and recommendations to the Senate Finance Committee and the House Economic Matters Committee by December 1, 2013.

- Requires the Commissioner to track complaints from customers regarding the sales practices of vendor employees at point of sale; determine whether and how vendor employees should be compensated for selling a portable electronics limited lines insurance policy; and report any findings and recommendations on or before January 1, 2017.

Effective Date: ***October 1, 2013***

SENATE BILL 736 (Chapter 311) – <u>Insurance – Fraudulent Insurance Acts – Compensation for Deductible</u>

- Prohibits a contractor who offers home repair or remodeling services for damages to a private residence caused by weather from directly or indirectly paying or otherwise compensating an insured or offering or promising to pay or compensate an insured, with the intent to defraud an insurer, for any part of the insured's deductible under the property or casualty insurance policy, if payment for the services will be made from the proceeds of the policy.

- Provides that a violation of the Act is a fraudulent insurance act subject to criminal and civil penalties.

Effective Date: ***October 1, 2013***

SENATE BILL 930 (Chapter 334) – <u>Property and Casualty Insurance – Premium Payments – Acceptance on Installment Payment Basis and Premium Finance Agreements</u>

MAIF Installment Payment Plan

- Authorizes MAIF to accept premiums on an installment payment basis on 12-month personal lines policies if specified requirements are met and the Commissioner approves.

- Requires that a MAIF installment plan:

    - In the case of a 12- month policy with a total annual premium less than $3,000, require an insured's initial premium payment to be at least 25% of the total annual premium, and offer no more than six installment payments on the 12-month policy;

- In the case of a 12- month policy with a total annual premium of $3000 or more, require an insured's initial premium payment to be at least 20% of the total annual premium and offer no more than eight installment payments on the 12-month policy; and

- Adjust the amount of the total annual premium used to determine the initial premium payment on October 1 of each year using data from the U.S. Government Bureau of Labor Statistics Motor Vehicle Insurance Expenditure Category of the Consumer Price Index for all Urban Consumers.

- Allows MAIF to impose an administrative processing fee of up to $8 per installment payment.

- Prohibits MAIF from discriminating among insureds by charging different premiums based on the payment option selected by an insured.

- Prohibits MAIF from considering whether a fund producer placed an insured in an installment payment plan in determining commissions paid to the fund producer.

- Requires any written and electronic communications, including MAIF's website, affecting the placement of coverage by MAIF or a fund producer to include a statement advising an applicant or an insured of the payment options available to the applicant or insured.

- Requires the Executive Director of MAIF, in consultation with the Commissioner and appropriate State agencies, to develop criteria for evaluating the effectiveness and impact of MAIF's installment payment plan, considering the plan's impact on: (1) the cost of automobile insurance for MAIF insureds; (2) the number of insured and uninsured motorists in the State; (3) the number of MAIF policies in force by geographic area; (4) the duration of MAIF policies in force; and (5) the frequency of payment methods used by MAIF insureds, including MAIF's installment payment plan, premium finance agreements, and cash and credit card payments.

- Requires MAIF to prepare a report on the effectiveness and impact of the installment payment plan for the prior year and, on or before October 1, 2015, submit the report to the Commissioner, who must submit a report on the effectiveness and impact of the installment payment plan to the Senate Finance Committee and the House Economic Matters Committee on or before December 31, 2015.

Premium Financing

- Adds notification requirements in a premium finance agreement, including a notification about the calculation of finance charges, and authorizes a premium finance company to include the monthly cost of a motor club service contract in the payments, but prohibits the premium finance company from earning finance charges on the amount of the motor club service contract.

- Requires finance charges under a premium finance agreement to be computed in an amount not exceeding the sum of 1.15% for each 30 days of the loan, computed in advance.

- Authorizes a premium finance company to use the actuarial method in calculating the amount of refund due an insured if the insurance contract is canceled or the insured prepays the loan in full at any time.

- Authorizes a premium finance company to earn the finance charge on the first day of each 30-day period.

- Imposes additional restrictions on the imposition of a finance charge in connection with a commercial automobile, fire, or liability insurance policy.

- Permits premium finance agreements for commercial insurance risks to include separate representations, warranties, or obligations of producers who sell, negotiate, or procure the insurance policy, the premiums for which are financed under the premium finance agreement.

- Prohibits a premium finance company from using the Rule of 78s to compute a finance charge.

- Authorizes premium finance companies to continue to charge finance charges for certain commercial insurance risks under specific circumstances if, after the policy is canceled and the premium is returned to the premium finance company, there remains an unpaid principal balance.

Cancellation Charges and Electronic Payment Fees

- Authorizes a premium finance agreement to impose a cancellation charge on or after the effective date stated in the notice of cancellation or on or after the cancellation effective date stated in the notice of intent to cancel.

- Increases the amount of a possible cancellation charge for private passenger automobile or personal fire or liability insurance by an additional dollar for each calendar year after 2014, increasing from $15 in calendar 2014 to $20 in calendar 2019 and for each subsequent year.

- Authorizes a premium finance company to charge an electronic payment fee if the insured elects to pay by electronic check.

Motor Club Service Contracts

- Includes motor club services in the definition of authorized add-on coverage sold in connection with a policy issued by MAIF.

- Prohibits a premium finance company from imposing a finance charge or any other charge on any payment for the purchase price of a motor club service contract.

- Prohibits a premium finance company from canceling an insurance contract if any payment under the premium finance agreement is sufficient to pay the installment due under the agreement that is related to the insurance contract obligation but is not sufficient to cover the amount of the monthly payment for the motor club service contract.

- Requires an insurance producer, or an employee or agent of the insurance producer, who directly or indirectly has an ownership interest in a motor club to provide a disclosure to be signed by the insured informing the insured of any interest the insurance producer, employee, or agent has in the motor club.

Assignment of Rights and Obligations

- Authorizes a premium finance company for private passenger motor vehicle insurance and personal insurance to assign all rights and obligations under a premium finance agreement to another premium finance company registered with the State or pledge a premium finance agreement as collateral for a loan.

- Authorizes a premium finance company for commercial automobile, fire, or liability insurance to assign all rights and obligations under a premium finance agreement to another person if the premium finance agreement expressly confers the right to assign all rights and obligations under the premium finance agreement or pledge a premium finance agreement as collateral for a loan. If the premium finance company assigns rights and obligations, it must retain the obligation to service the premium finance agreement or assign the obligation to another finance company registered with the State.

- Requires a premium finance company who assigns obligations to service a premium finance agreement to provide the insured specified notice.

Effective Date: ***July 1, 2013***

OTHER

HOUSE BILL 431 (Chapter 115) – Insurance – Maryland Insurance Acquisitions Disclosure and Control Act – Revisions

- Requires a person seeking to acquire control of a domestic insurer to file a pre-acquisition notification and statement regarding the acquisition with the Commissioner.

- Requires prior notice of a proposed divesture of control of a domestic insurer by a controlling person to be filed with the Commissioner.

- Requires a person seeking to acquire control of a domestic insurer to agree to provide the Commissioner with an annual enterprise risk report and any information necessary for the Commissioner to evaluate the insurer's enterprise risk.

- Requires an insurer that is a member of an insurance holding company system to file statements that the insurer's board of directors oversees corporate governance and internal controls, and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

- Beginning in 2015, requires the ultimate controlling person of an insurer that is a member of a holding company system to file with the Commissioner an annual enterprise risk report identifying material risks within the holding company system that could pose enterprise risk to the insurer.

- Requires an insurer, upon request from the Commissioner, to provide financial statements of an insurance holding company system including all affiliates.

- Expands the Commissioner's examination authority to include all entities within the insurance holding company system.

- Sets the amount of time before a disclaimer of affiliation with domestic insurers becomes effective at 60 days after the time of filing if not disallowed by the Commissioner.

- Authorizes the Commissioner to specify provisions by regulation that must be included in management agreements, service contracts, tax allocation agreements, or cost-sharing agreements.

- Increases and establishes fines and penalties for a violation of specified provisions of the Act.

- Authorizes the Commissioner to participate in supervisory colleges, which are meetings of state and international regulatory agencies supervising insurers and their affiliates, and requires insurers to be responsible for reimbursement of reasonable expenses for the Commissioner's participation.

- Requires prior notice to the Commissioner of amendments or modifications of existing affiliate agreements previously filed by an insurer.

- Requires notice to the Commissioner of termination of existing agreements or transactions previously filed by an insurer.

Effective Date: ***January 1, 2014***

HOUSE BILL 537 (Chapter 377) – Insurance Producers – Continuing Education – Online Courses

- Authorizes all insurance producers required to meet continuing education requirements for renewal of their licenses to obtain all or part of the required continuing education credits through correspondence or online courses approved by the Commissioner.

Effective Date: ***October 1, 2013***

HOUSE BILL 724 (Chapter 385) – Insurance – Risk Based Capital Standards – Fraternal Benefit Societies and Life Insurers

- Requires that a fraternal benefit society meet specified risk based capital requirements and be subject to both a company action level event and a mandatory control level event.

- Raises the minimum level of total adjusted capital that triggers a company action level event for a life insurer or fraternal benefit society.

Effective Date: ***October 1, 2013***

HOUSE BILL 1205 (Chapter 407) – Study of Captive Insurers

- Requires the MIA to examine methods to establish and properly regulate a captive insurer industry in the State. The study includes:

    - The models of regulation of captive insurance industries in other states;

    - The potential benefits of hosting a captive insurance industry in the State;

    - The impact on the State and the domestic insurance industry; and

    - The need for different or additional consumer protections and financial controls for customers of the captive insurers.

Effective Date: ***June 1, 2013***

SENATE BILL 777 (Chapter 321) – Insurance – Ceding Insurers and Reinsurance

- Alters the requirements for a licensed ceding insurer to receive credit for reinsurance in their financial statements and authorizes the Commissioner to certify reinsurers so that licensed ceding insurers may receive credit for reinsurance ceded to certified reinsurers.

- Requires new contractual provisions for the ceding insurer to obtain credit for reinsurance.

- Establishes the eligibility requirements to be considered for certification as a certified reinsurer.

- Establishes a method whereby an assuming insurer may be certified and rated by the Commissioner and allows insurers ceding to an assuming insurer that has been certified to be granted full credit for reinsurance while being permitted to obtain security according to a sliding scale, with the required collateral varying from 0% to 100% of ceded liabilities according to the certified reinsurer's rating.

- Requires the Commissioner to publish a list of all certified reinsurers and their ratings.

- Requires a certified reinsurer to meet specified requirements relating to secured obligations. In order for a domestic ceding insurer to qualify for full financial statement credit, the certified reinsurer must maintain security in a form the Commissioner considers acceptable and consistent with specified requirements or in a specified multibeneficiary trust.

- Requires a certified reinsurer to report certain information to the Commissioner annually.

- Requires the certified reinsurer to bind itself, by the language of the trust and agreement with the regulatory agency with principal regulatory oversight of each trust account, to fund, on termination of the trust account, out of the remaining surplus of the trust, any deficiency of any other trust account.

- Establishes the eligibility requirements of a jurisdiction in which an assuming insurer may be domiciled to be considered a qualified jurisdiction and requires the Commissioner to maintain and publish a list of qualified jurisdictions. The bill prohibits the Commissioner from recognizing as a qualified jurisdiction a jurisdiction that the Commissioner determines does not adequately and promptly enforce final U.S. judgments and arbitration awards.

- Requires that the reduced collateral provisions for a certified reinsurer apply to reinsurance contracts entered into on or after the effective date of the certification, and that any reinsurance contract entered into prior to the effective date of certification that subsequently is amended and any new reinsurance agreement covering risk for which collateral previously was provided, will qualify for reduced collateral only with respect to losses incurred and reserves reported from and after the effective date of the amendment or contract.

- Authorizes the insurance regulatory agency with principal regulatory oversight of the trust to reduce the required trusteed surplus at any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years. A reduction may be authorized only after a determination, based on an assessment of the risk, is made that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial

review and must consider all material risk factors. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

- Requires notification if reinsurance recoverables from any single reinsurer or group of affiliated reinsurers exceed 50% of the insurer's last reported surplus to policyholders or if the insurer has ceded to any single reinsurer or group of affiliated reinsurers more than 20% of the insurer's gross written premium in the prior calendar year.

- Authorizes the Commissioner to suspend or revoke, after providing notice and an opportunity for a hearing to the reinsurer, a reinsurer's accreditation or certification if the reinsurer ceases to meet the requirements for accreditation or certification. Any revocation or suspension does not take effect until after the Commissioner's order on hearing unless (1) the reinsurer waives its right to a hearing; (2) the Commissioner's order is based on a regulatory action by the reinsurer's domiciliary jurisdiction or primary certifying state suspending or revoking the reinsurer's eligibility to transact insurance or reinsurance; (3) the reinsurer voluntarily surrenders its license or certification to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state; or (4) the Commissioner finds that an emergency requires immediate action by the Commissioner and a court of competent jurisdiction has not stayed the Commissioner's action.

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