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Lt. Governor

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BULLETIN 09-23

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

Re: **Summary of 2009 Insurance Legislation Signed into Law by Governor Martin O'Malley**

Date: **August 2009**

This summary is meant to place insurers, non-profit health service plans, health maintenance organizations, dental plan organizations, pharmacy benefits managers, and producers (hereinafter "regulated entities") authorized to do business in Maryland on notice of certain laws passed during the 2009 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration (MIA). ***The attached synopsis is intended only as notice of the passage of the legislation and is not a representation of the MIA's interpretation of the legislation, nor is it a representation of how the MIA may choose to enforce these new provisions.*** All regulated entities should refer to the 2009 Chapter Laws of Maryland for the complete text of these recently enacted laws. Regulated entities are advised that other bills passed by the General Assembly and not listed on the synopsis may also affect their business operations in Maryland.

You can obtain a copy of a specific law passed by the General Assembly during the 2009 legislative session by accessing the Maryland General Assembly's web site at http://mlis.state.md.us on the internet or by contacting the Department of Legislative Services at 410-946-5400. You should refer to the House or Senate Bill number when searching for a law on the web site. You can also obtain a copy of *"The 90 Day Report – A Review of the 2009 Legislative Session"* on the internet or from Library and Information Services, Office of Policy Analysis, Department of Legislative Services.

For additional information concerning the Maryland Insurance Administration's summary of 2009 insurance legislation, please contact Tinna Damaso Quigley, Director of Government Relations and Policy Development, at 410-468-2202.

2009 INSURANCE LEGISLATION

LIFE AND HEALTH

HOUSE BILL 32 (Chapter 653) – Health Insurance – Limitations on Preexisting Condition Provisions – Individual Health Benefit Plans (*See also* SENATE BILL 79)

- Prohibits a health insurance application form or nonprofit health service plan application form for individual health benefit plans from containing inquiries about:

  (1) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice during the five years immediately before the date of application; or

  (2) medical screening, testing, monitoring, or any other similar medical procedure that the applicant received during the five years immediately before the date of application.

- Prohibits a carrier from attaching an exclusionary rider to an individual health benefit plan unless the carrier obtains the prior written consent of the policyholder.

- Authorizes a carrier to impose a preexisting condition exclusion or limitation on an individual for a condition that was not discovered during the underwriting process only if the exclusion or limitation:

  (1) relates to a condition for which medical care was received during the 12-month period immediately preceding the effective date of the individual's coverage;

  (2) extends for a period of not more than 12 months after the effective date of the coverage; and

  (3) is reduced by the aggregate of any applicable periods of creditable coverage.

- Prohibits a carrier from imposing a preexisting condition exclusion or limitation on an individual who is covered under any creditable coverage as specified but may be imposed on or after the end of the first 63-day period during which the individual was not covered for the entire period under any creditable coverage.

Effective Date: ***October 1, 2009***

HOUSE BILL 39 (Chapter 654) – Health Insurance – Out-of-State Association Contracts – Regulation (*See also* SENATE BILL 79)

- Requires a carrier that requires evidence of insurability and offers coverage under an out-of-state association contract to Maryland residents to disclose to an applicant:

  (1) that coverage is conditioned on association membership;

(2) all costs related to joining and maintaining membership in the association;

(3) that membership fees or dues are in addition to the premium for coverage;

(4) that the terms and conditions of coverage are determined by the association and carrier;

(5) the health insurance benefits otherwise mandated in Maryland that are not included in the contract;

(6) that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits that are not included in the contract;

(7) that the benefits offered under the contract are not regulated by the Insurance Commissioner; and

(8) that the terms and conditions of coverage may be changed without the consent of a member.

- Requires a carrier that collects membership fees or dues on behalf of an association to disclose this information on the enrollment application.

- Authorizes the Insurance Commissioner to require a carrier that provides coverage under an out-of-state association contract to report annually to the Insurance Commissioner on the number of State residents covered under the out-of-state association contract.

Effective Date: ***October 1, 2009***

HOUSE BILL 41 (Chapter 517) / SENATE BILL 173 (Chapter 516) – Health Insurance – Mandated Benefits – Hospitalization and Home Visits Following a Mastectomy

- Require insurers, nonprofit health service plans, and HMOs to provide coverage for a minimum 48-hour inpatient hospital stay following a mastectomy.

- Require, for a patient who receives less than a 48-hour inpatient stay or who undergoes a mastectomy on an outpatient basis, a carrier to provide coverage for one home visit scheduled to occur within 24 hours after discharge and an additional home visit, if prescribed.

- Prohibit carriers from denying, limiting, or impairing the participation of physicians under contract with the carrier for advocating the interest of mastectomy patients, including lengthier inpatient stays or additional home visits.

- Require carriers to provide an annual notice to insureds and enrollees about the coverage.

Effective Date: ***October 1, 2009***

HOUSE BILL 145 (Chapter 550) / SENATE BILL 481 (Chapter 549) – Health Insurance – Dental Provider Panels – Provider Contracts

- Prohibit a provider contract from requiring a provider, as a condition of participating in a fee-for-service dental provider panel, to participate in a capitated dental provider panel.

- Require the MIA to review dental provider contracts, the terms and conditions of the contracts, and the impact that the contracts have on the dental profession and report its findings and recommendations by December 31, 2009, to the House Health and Government Operations Committee and the Senate Finance Committee.

Effective Date: ***June 1, 2009***

HOUSE BILL 235 (Chapter 663) – Health Insurance – Rescission of Contracts and Certificates – Restrictions (*See also* SENATE BILL 79)

- Prohibits an insurer, nonprofit health service plan, or a health maintenance organization that conditions coverage for a health benefit plan on evidence of individual insurability from rescinding coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan.

- Requires a carrier to prove that any rescission of a health benefit plan complies with the law's provisions.

Effective Date: ***October 1, 2009***

HOUSE BILL 255 (Chapter 664) – Health Maintenance Organizations – Payments to Nonparticipating Providers

- Requires, for services that are not evaluation and management services, a health maintenance organization (HMO) to pay noncontracting health care providers no less than 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, to a similarly licensed contracting provider for the same covered service.

- Requires, for covered evaluation and management services, an HMO to pay a noncontracting health care provider at the greater of:

  (1) 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, for the same covered service, to similarly licensed contracting providers; or

  (2) 140% of the Medicare rate for the same covered service, to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by change in the Medicare Economic Index.

- Requires an HMO to calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service using a calculation of the sum of the contracted rate for all occurrences of the Current Procedural Terminology (CPT) code for that service divided by the total number of occurrences of the CPT code.

- No changes made to current requirement regarding payment to nonparticipating providers rendering trauma services to HMO members.

- Authorizes the MIA to investigate and enforce a violation of the law.

- Requires the Maryland Health Care Commission (MHCC) to annually review payment to health care providers to determine compliance with the bill and report its findings to the MIA.

- Requires the MIA, in consultation with the MHCC, to promulgate regulations.

Effective Date: ***January 1, 2010***

Termination Date: ***December 31, 2014***

HOUSE BILL 405 (Chapter 670) – <u>Health Insurance – Mandated Benefits – Breast Cancer Screening</u>

- Requires insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

Effective Date: ***October 1, 2009***

HOUSE BILL 440 (Chapter 67) / SENATE BILL 439 (Chapter 66) – <u>Health Insurance – Prompt Pay – Clarifications</u>

- Clarify that if an insurer, nonprofit health service plan, or health maintenance organization (HMO) fails to pay a clean claim for reimbursement or otherwise violates clean claims requirements, the insurer, nonprofit health service plan, or HMO must pay interest on the amount of the claim that remains unpaid 30 days after the receipt of the initial clean claim for reimbursement.

Effective Date: ***October 1, 2009***

HOUSE BILL 456 (Chapter 113) / SENATE BILL 985 (Chapter 112) – <u>Health Insurance – Coverage for Off-Label Use of Drugs – Standard Reference Compendia</u>

- Alter the definition of "standard reference compendia" for purposes of mandated coverage of off-label use of drugs to mean any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Insurance Commissioner.

Effective Date: ***October 1, 2009***

HOUSE BILL 503 (Chapter 338) / SENATE BILL 963 (Chapter 337) – Health – Maryland Commission on Autism

- Establish the Maryland Commission on Autism to make recommendations regarding services for individuals with autism spectrum disorders; develop a statewide plan for a system of training, treatment, and services for individuals with autism; evaluate ways to promote autism spectrum disorder awareness; and review the findings of any summit or conference convened by the State regarding autism spectrum disorders.

- Require the commission to report its preliminary findings and recommendations to the General Assembly by June 1, 2011, and its final report by September 30, 2012.

Effective Date: ***October 1, 2009***

Termination Date: ***September 30, 2012***

HOUSE BILL 526 (Chapter 91) / SENATE BILL 646 (Chapter 90) – Credentialing of Health Care Providers by Managed Care Organizations, Insurance Carriers, and Hospitals

- Authorize the Insurance Commissioner to designate as the uniform credentialing form a credentialing application developed by a nonprofit alliance of health plans and trade associations for an online credentialing system if the application is available to providers at no charge and use of the application is not conditioned on submitting the application to a carrier online.

Effective Date: ***October 1, 2009***

HOUSE BILL 537 (Chapter 580) / SENATE BILL 645 (Chapter 579) – Fraternal Benefit Societies – Exemption for Mutual Aid Associations – Clarification

- Clarify that the statutory exemption granted to fraternal benefit societies from regulation under the insurance laws of the State also includes an association comprising active duty, reserve, honorably discharged, and retired members of the Armed Forces or Sea Services of the United States that organized prior to 1880.

Effective Date: ***October 1, 2009***

HOUSE BILL 579 (Chapter 244) / SENATE BILL 341 (Chapter 243) – Prosthetic Parity Act

- Require insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for prosthetic devices, components of prosthetic devices, and repair of prosthetic devices.

- Prohibit prosthetic devices from being subject to a higher copayment or coinsurance requirement than those required for any primary care benefits.

- Prohibit a carrier from imposing an annual or lifetime dollar maximum on coverage for prosthetic devices, separate from any maximum that applies in the aggregate to all covered benefits.

- Prohibit a carrier from establishing requirements for medical necessity or appropriateness for prosthetic devices that are more restrictive than those under the Medicare Coverage Database.

Effective Date: ***October 1, 2009***

HOUSE BILL 585 (Chapter 586) / SENATE BILL 661 (Chapter 585) – Health Insurance – Use of Physician Rating Systems by Carriers

- Establish requirements for the MHCC to approve ratings examiners to review physician rating systems.

- Provide for the recognition of a national consortium of employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information as an approved ratings examiner.

- Prohibit health insurance carriers from using a physician rating system unless the system is approved by a ratings examiner.

- Require health insurance carriers to establish an appeals process for physicians to contest a rating in the system and to disclose any changes in evaluations to physicians at least 45 days before making the information available to enrollees.

- Require the MIA to report annually to the Governor and the General Assembly on the number and types of appeals that have been filed by physicians with carriers regarding an evaluation in a physician rating system and the number of entities that the MHCC has approved as ratings examiners.

- Require a health insurance carrier to post certain information regarding the carrier's physician rating system on the section of the carrier's website that discloses the rating of a physician to enrollees or to the public.

Effective Date: ***January 1, 2010***

HOUSE BILL 590 (Chapter 598) / SENATE BILL 716 (Chapter 597) – Long-Term Care Insurance – Annuity Contracts and Qualified State Long-Term Care Insurance Partnership

- Repeal the requirement that the outline of coverage, which carriers must provide to long-term care insurance applicants, include a statement as to whether the policy or contract is approved under the Qualified State Long-Term Care Insurance Partnership.

- Require a certificate issued under group long-term care insurance include a statement as to whether the policy or contract is intended to qualify as a partnership policy under the Qualified State Long-Term Care Insurance Partnership.

- Authorize an annuity contract to include a rider or supplemental contract provision that offers a contract holder reimbursement or payment for long-term care.

Effective Date: ***June 1, 2009***

HOUSE BILL 674 (Chapter 578) / SENATE BILL 637 (Chapter 577) – Health Insurance – Small Group Market Regulation – Modifications

- Permit preexisting condition limitations to the extent that they are allowed in the large group market.

- Remove the floor on the Comprehensive Standard Health Benefit Plan (CSHBP).

- Permit the use of health status in rating upon entry of a small employer that did not previously have a health benefit plan for 12 months prior to application into the small group, phased out over a period of three years. A carrier may charge based on this adjustment for health status an additional:

  (1) 10% above or below the community rate in the first year of enrollment;

  (2) 5% above or below the community rate in the second year of enrollment; and

  (3) 2% above or below the community rate in the third year of enrollment.

- Authorize health insurance carriers to vary a rate charged for a health benefit plan in the small group up to 50% above or below the community rate based on age and geography.

- Require the MHCC to develop and maintain a mechanism on its web site that small businesses may use to compare premiums for health benefit plans.

- Require the MHCC to report to the Governor and the General Assembly by December 1, 2009, on potential options for allowing plans with fewer benefits than the CSHBP to be sold in the small group market and whether any additional authority is needed to effectively implement the premium comparison application.

Effective Date: ***July 1, 2010 for the provisions relating to the use of health status in rating and the varying of a rate up to 50% above or below the community rate based on age and geography. October 1, 2009 for the balance of the provisions.***

HOUSE BILL 706 (Chapter 689) – Electronic Health Records – Regulation and Reimbursement

- Requires the MHCC to adopt regulations requiring the State Employee and Retiree Health and Welfare Benefits Program and carriers that issue or deliver health benefit plans in the State to provide incentives to providers to promote the adoption and meaningful use of electronic health records (EHR). Any incentives must have monetary value, facilitate the use of EHR, recognize and be consistent with existing payor incentives, and take into account certain federal incentives.

- Requires the MHCC and the Health Services Cost Review Commission (HSCRC) to designate a State health information exchange (HIE), and the MHCC to designate one or more management service organizations to offer EHR services.

- Requires, beginning the latter of January 1, 2015, or the date established for the imposition of penalties under the American Reinvestment and Recovery Act of 2009 (ARRA), each provider using EHR that seeks payment from a State-regulated payor to use EHR that are certified by a national certification organization designated by the MHCC and capable of connecting to and exchanging data with the State HIE.

- Authorizes State-regulated payors to reduce payments to health care providers for noncompliance with the above requirements.

- Requires the HSCRC, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services (CMS), to assure that hospitals receive payments provided under the ARRA and implement any changes in hospital rates required by CMS to ensure compliance with ARRA.

- Requires the MHCC to adopt regulations by September 2011 requiring carriers to incentivize providers to adopt a meaningful use of electronic medical records.

- Requires the Department of Health and Mental Hygiene, in consultation with the MHCC, to develop a mechanism to assure that health care providers that participate in Medicaid receive the payments provided for adoption and use of EHR technology under ARRA.

Effective Date: ***July 1, 2009***

HOUSE BILL 725 (Chapter 315) / SENATE BILL 791 (Chapter 314) – <u>Group Model Health Maintenance Organizations – Drug Therapy Management</u>

- Allow licensed physicians and licensed pharmacists to provide drug therapy management, provided they have a physician-pharmacist agreement approved by either the State Board of Pharmacy or State Board of Physicians.

- Require drug therapy management to be provided under a physician-pharmacist agreement that is approved by the State Board of Pharmacy and State Board of Physicians and must also be provided through the internal pharmacy operations of the HMO.

- Require a licensed physician or licensed pharmacy to inform a patient:

  (1) of drug therapy management procedures;

(2) that he or she may decline to participate or withdraw from drug therapy management participation at any time; and

(3) that neither the physician nor pharmacist has been coerced or given economic incentives, except for normal reimbursement, or involuntarily required to participate.

- Require a licensed physician or licensed pharmacy to obtain the patient's documented informed consent to participate in drug therapy management after making the required disclosure.

Effective Date: ***October 1, 2009***

HOUSE BILL 1071 (Chapter 104) / SENATE BILL 854 (Chapter 103) – Health Insurance – Definition of Coverage Decisions – Pharmacy Inquiries

- Exclude a "pharmacy inquiry" from the definition of coverage decision for purposes of the internal appeals process for carrier coverage decisions and subsequent complaints to the Insurance Commissioner.

- Define a "pharmacy inquiry" as an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

Effective Date: ***October 1, 2009***

HOUSE BILL 1195 (Chapter 170) – Prescription Drugs – Wholesale Drug Distribution – Surety Bond Requirements

- Alters the amount of the surety bond or other security that applicants for a wholesale pharmaceutical distribution permit must submit with their application in the following manner:

  (1) from $100,000 in all cases to $100,000 only if the applicant's annual gross receipts from the sale of prescription drugs or devices in the State for the previous tax year are $10,000,000 or more; and

  (2) $50,000 if the applicant's annual gross receipts for the previous tax year are less than $10,000,000.

- Authorizes the Board of Pharmacy to allow a wholesaler that submitted a $100,000 bond or other security prior to the law's enactment to reduce the amount if the wholesaler qualifies for the $50,000 surety bond or other security.

- Requires a wholesale distributor permit applicant to submit a surety bond or other security payable to the Board of Pharmacy rather than to an account established by the State.

Effective Date: ***April 14, 2009***

HOUSE BILL 1472 (Chapter 734) – <u>Health Insurance – Senior Prescription Drug Assistance Program – Funding</u>

- Clarifies that there are two subsidies provided to the Senior Prescription Drug Assistance Program (SPDAP):

  (1) a subsidy under § 14-106 of the Insurance Article, which funds the SPDAP premium subsidy and is capped at $14.0 million in fiscal 2010; and

  (2) a subsidy under § 14-106.2 of the Insurance Article, which provides assistance with the Medicare Part D coverage gap and is provided in an amount of $4.0 million in years in which CareFirst incurs a specified surplus.

- Alters the timing of the second subsidy to simplify administration of SPDAP by providing that, beginning with calendar 2009, CareFirst must transfer $4.0 million to SPDAP if it has a surplus that exceeds 800% of specified consolidated risk-based capital (RBC) requirements. CareFirst is not required to make the transfer if its surplus does not exceed the specified level. The RBC threshold for determining the transfer is based on the corporation's annual March 1 filing with the Maryland Insurance Administration. By September 1 of each year, CareFirst has to notify SPDAP whether it will transfer the $4.0 million subsidy during the next calendar year. CareFirst must pay the $4.0 million subsidy to SPDAP in quarterly installments of $1.0 million beginning October 1.

Effective Date: ***July 1, 2009***

HOUSE BILL 1534 (Chapter 349) / SENATE BILL 1070 (Chapter 348) – <u>Nonprofit Health Service Plans – Hearing and Order – Impact of Law by Another State</u>

- Authorize the Insurance Commissioner to hold a hearing if another state enacts a law that requires a nonprofit health service plan operating in Maryland to provide a program or benefits for the residents of another state. The hearing would review and evaluate the impact of the law on the nonprofit health service plan, including the impact on surplus, premium rates for policies issued or delivered in Maryland, and solvency.

- Require the Insurance Commissioner to determine whether the impact on the nonprofit health service plan is harmful to the interests of subscribers covered by policies issued or delivered in Maryland and issue an appropriate order to protect the subscribers, where necessary.

- Authorize the order by the Insurance Commissioner to prohibit the nonprofit health service plan from subsidizing the program or benefits for the residents of another state through premiums charged to subscribers under policies issued or delivered in Maryland or use of any surplus earned through policies issued or delivered in Maryland.

Effective Date: ***June 1, 2009***

SENATE BILL 79 (Chapter 509) – Health Insurance - Reform

- Includes all of the provisions of HOUSE BILL 32, HOUSE BILL 39, and HOUSE BILL 235. See each bill for a description.

Effective Date: ***July 1, 2009***

SENATE BILL 84 (Chapter 22) – Health Insurance – Medicare Coverage and Continuation Coverage – Provisions That Relate to Federal Laws and Programs

- Requires carriers that sell Medicare supplement plan policies to make available a Medicare supplement policy plan A to disabled individuals younger than age 65 during the six-month period after the individual enrolls in Medicare Part B. Prohibits a carrier from charging these individuals a rate higher than the average of the premiums paid by all policyholders age 65 and older in the State who are covered under that plan A policy.

- Authorizes individuals in small firms who were involuntarily terminated from their jobs to have a second opportunity to elect continuation coverage of their health benefits and obtain a federal subsidy of their premium.

- Alters minimum requirements for Medicare supplement policies to align with the minimum benefits required by federal law.

Effective Date: ***April 14, 2009***

SENATE BILL 636 (Chapter 89) – Health Insurance – Required Report and Repeal of Obsolete Provisions

- Repeals a provision of law that would apply the rules of the small group health insurance market to the entire commercial market if and when a certain trigger is reached.

- Requires the Insurance Commissioner, by December 1 of each year, to report to the General Assembly on the estimated number of insured and self-insured contracts for health benefit plans in the State and the number of insured and self-insured lives younger than age 65 enrolled in health benefit plans in the State.

- Repeals an obsolete reporting requirement of the MIA.

Effective Date: ***October 1, 2009***

SENATE BILL 638 (Chapter 683) / HOUSE BILL 610 (Chapter 682) – Health Insurance – Bona Fide Wellness Programs – Incentives

- Expand the definition of “bona fide wellness program” to include programs designed to promote health or prevent and control injury.

- Conform the definition of “wellness benefit” in the small group health insurance market to the provisions of the law.

- Prohibit a carrier from making participation in a bona fide wellness program a condition of coverage.

- Require participation in a bona fide wellness program to be voluntary.

- Prohibit a penalty from being imposed on an insured, subscriber, or member for nonparticipation in a bona fide wellness program.

- Prohibit a carrier from marketing the bona fide wellness program solely as an incentive or inducement to purchase coverage from the carrier.

- Prohibit a bona fide wellness program from conditioning an incentive on an individual satisfying a standard related to a health factor except as specified.

- Authorize incentives to be based on an individual satisfying a standard related to a health factor if:

  (1) all incentives for participation do not exceed 20% of the cost of specified coverage under the plan;

  (2) the program is reasonably designed to promote health or prevent disease;

  (3) the program gives individuals the opportunity to qualify for the incentive at least annually;

  (4) the program is available to all similarly situated individuals; and

  (5) individuals are provided a reasonable alternative standard or a waiver of the standard.

- Require a bona fide wellness program to be construed to be reasonably designed to promote health or prevent disease if the program:

  (1) has a reasonable chance of improving the health of or preventing disease in participating individuals;

  (2) is not overly burdensome;

  (3) is not a subterfuge for discriminating based on a health factor; and

  (4) is not highly suspect in the method chosen to promote health or prevent disease.

- Require a carrier to provide a reasonable alternative standard or a waiver of the standard for any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the otherwise applicable standard.

- Authorize a carrier to seek verification that a health factor makes it unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the otherwise applicable standard.

- Require a carrier to disclose the availability of a reasonable alternative standard or waiver.

- Provide that a denial by a carrier of a request for an alternative standard or waiver of a standard constitutes an adverse decision.

- Authorize the Insurance Commissioner to request a review of a carrier's bona fide wellness program by an independent review organization to determine if the program meets the law's requirements.

- Require the expense of the review of a carrier's bona fide wellness program to be paid by the carrier.

Effective Date: ***October 1, 2009***

PROPERTY AND CASUALTY

HOUSE BILL 141 (Chapter 131) – Insurance – Insurer Provider Panels – Health Care Providers

- Prohibits a property and casualty insurer from using an insurance provider panel if the provider contract for the insurer provider panel requires a provider to participate on the insurer provider panel as a condition of participating on an HMO or non-HMO provider panel.

- Requires an entity arranging an insurer provider panel to provide a health care provider with a schedule of applicable fees for up to the 50 most common services billed by a provider in that specialty at the time of contract, 30 days prior to a change, or upon request of the health care provider.

Effective Date: ***October 1, 2009***

HOUSE BILL 161 (Chapter 375) – Insurance – Company Action Level Events – Property and Casualty Insurers

- Establishes, for property and casualty insurers, an additional company action level threshold with respect to risk-based capital (RBC).

- Provides that a company action level event for a property and casualty insurer occurs when total adjusted capital:

  (1) is greater than or equal to its company action level RBC;

  (2) is less than the product of its authorized control level RBC and 3.0; and

(3) triggers the trend test calculation in the property and casualty RBC instructions.

Effective Date: ***October 1, 2009***

HOUSE BILL 162 (Chapter 376) – <u>Insurance – Notice of Premium Increase for Commercial and Workers' Compensation Insurance</u>

- Requires insurers that write policies of commercial insurance and workers' compensation insurance to provide notice of the renewal policy premium to the named insured and insurance producer, if any, at least 45 days prior to the renewal date, regardless of the amount of the policy premium increase.

- Allows an insurer to meet the notice requirement by including the new premium in a renewal policy, notice of renewal or continuation of coverage, or renewal offer that includes a reasonable estimate of the renewal policy premium.

- Exempts policies issued to a commercial policyholder that pays aggregate property and casualty premiums of at least $25,000 per year and meets certain revenue, net worth, employment, or other relevant criteria from the notice requirements of the law.

Effective Date: ***January 1, 2010***

HOUSE BILL 164 (Chapter 378) – <u>Automobile Liability and Homeowner's Insurance – Rating, Retiering, and Discounts</u>

- Prohibits an insurer under a homeowner's insurance policy from classifying or maintaining an insured for more than three years in a classification that entails a higher premium due to a specific claim.

- Prohibits an insurer under a homeowner's insurance policy from reviewing a period beyond the three years prior to the application date or proposed effective date for a new policy, or the effective date of the renewal for a renewal policy.

- Provides that the removal of, reduction of, or refusal to apply a discount does not violate the law's provisions if the action results from a claim filed within the preceding five years.

- Provides that an insurer that grants a claim-free discount to an insured under a homeowner's or automobile liability insurance policy does not violate the law.

- Prohibits an insurer under personal injury protection coverage from retiering a policy for a claim made under that coverage, in addition to the prohibition of a surcharge for such a claim.

Effective Date: ***January 1, 2010***

HOUSE BILL 165 (Chapter 379) – <u>Insurance – Cancellation of Policies – Limitations on Midterm Cancellations</u>

- Prohibits insurers that write policies of personal insurance, commercial insurance, and private passenger motor vehicle insurance from cancelling policies midterm except under specified circumstances.

- Is applicable to insurers that write policies of homeowner's insurance under which a one-time guaranteed fully refundable deposit is required for a stated amount of coverage.

- Authorizes an insurer to cancel a policy midterm only when there is:

  (1) a material misrepresentation or fraud in connection with the application, policy, or presentation of a claim;

  (2) a matter or issue related to the risk that constitutes a threat to public safety;

  (3) a change in the condition of the risk that results in an increase in the hazard insured against;

  (4) nonpayment of premium;

  (5) suspension or revocation of the driver's license or motor vehicle registration of a named insured or covered driver for reasons related to the driving record of the named insured or covered driver; or

  (6) in the case of homeowner's insurance only, an arson conviction.

Effective Date: ***October 1, 2009***

HOUSE BILL 287 (Chapter 523) / SENATE BILL 201 (Chapter 522) – <u>Real Property – Condominiums – Repair or Replacement of Damage or Destruction by Council of Unit Owners</u>

- Clarify that the responsibility of a condominium's council of unit owners to repair or replace the common elements of a condominium extends to the condominium units, exclusive of improvements installed in the units by unit owners other than the developer, in the event of damage or destruction to the condominium – notwithstanding inconsistent provisions in the council of unit owners' bylaws.

- Require the condominium's council of unit owners to maintain property insurance on the common elements and units, exclusive of improvements installed in the units by unit owners other than the developer.

- Require a unit owner to pay the deductible of the condominium's master insurance policy, up to the statutory limit of $5,000, if the cause of the damage originated from the owner's unit.

- Require notice of a unit owner's responsibility for the insurance deductible to be included in a condominium sales contract and given annually in writing by the council of unit owners to each unit owner.

Effective Date: ***June 1, 2009***

HOUSE BILL 648 (Chapter 99) / SENATE BILL 768 (Chapter 98) – Commercial Insurance and Workers' Compensation Insurance – Renewals of Policies – Transfers of Policyholders Between Insurers

- *See also HOUSE BILL 162.*

- Classify the transfer of a policyholder by a commercial insurer or workers' compensation insurer to an affiliate within the same insurance holding company system as a renewal, rather than a cancellation or intention not to renew the policy, if the premium does not increase and there is no reduction in coverage.

- Classify the issuance of a new policy to replace an expiring policy of commercial insurance or workers' compensation insurance issued by an affiliate within the same insurance holding company system as a renewal if the premium does not increase and there is no reduction in coverage.

- Require the commercial insurer or workers' compensation insurer providing the new policy to notify the policyholder of the transfer.

Effective Date: ***June 1, 2009 (provisions relating to the transfer of a policyholder)***

January 1, 2010 (provisions relating to House Bill 162)

HOUSE BILL 687 (Chapter 78) / SENATE BILL 541 (Chapter 77) – Common Ownership Communities – Fidelity Insurance

- Require the governing body of a common ownership community to purchase fidelity insurance no later than the time of the first conveyance of a unit or lot to a person other than the developer.

- The fidelity insurance provides for the indemnification of the common ownership community against losses resulting from acts or omissions arising from fraud, dishonesty, or criminal acts by the common ownership community's officers, directors, managing agents, management companies, or associated agents or employees.

- Require the amount of the fidelity insurance to equal the lesser of either three months' worth of gross common charges or annual charges and the total amount held in all investment accounts at the time the fidelity insurance is issued or $3,000,000.

Effective Date: ***October 1, 2009***

HOUSE BILL 868 (Chapter 317) / SENATE BILL 792 (Chapter 316) – Property and Casualty Insurance – Portable Electronics Insurance – Regulation

- Require a vendor to hold a limited lines license to sell a portable electronics insurance policy in connection with a portable electronics transaction.

- Define a vendor as a person in the business of leasing, selling, or providing portable electronics, or selling or providing service related to their use, to customers in the State.

- Define a portable electronics transaction as:

  (1) the sale or lease of portable electronics by a vendor to a customer; or

  (2) the sale of service related to the use of portable electronics.

- Authorize a vendor to use supervised employees or authorized representatives to sell or offer coverage if they are trained in accordance with the law's requirements.

- A limited lines license issued authorizes the vendor or the vendor's employees or authorized representative to sell a portable electronics insurance policy if:

  (1) the policies have been filed with and approved by the Insurance Commissioner;

  (2) the vendor holds an appointment with each authorized insurer that the vendor intends to represent; and

  (3) the vendor provides certain disclosures approved by the Insurance Commissioner at each sale location.

- Specify that coverage under a policy of portable electronics insurance sold in connection with a portable electronics transaction is primary to other valid and collectible coverage, such as homeowner's, renter's, and private passenger automobile insurance policies.

- Authorize the Insurance Commissioner to suspend, revoke, or refuse to renew a limited lines license issued to a vendor after notice and hearing if the vendor or an employee or authorized representative of the vendor has committed any of a list of violations or prohibited omissions.

- Authorize the Insurance Commissioner to, instead of or in addition to taking action against the licensee, impose fines of up to $2,500 per violation and require restitution to any person who has suffered financial injury because of the violation.

- Authorize portable electronics insurance to be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor under which individual customers may elect to purchase coverage.

- Except as otherwise specified, prohibit an insurer from terminating or changing the terms and conditions of a portable electronics insurance policy without providing the policyholder and covered customers with at least 60 days' notice.

- Authorize termination of coverage after 45 days' notice if the vendor discovers fraud or a material misrepresentation in obtaining coverage or in the presentation of a claim, and after 10 days' notice for nonpayment of premium.

- Authorize automatic termination of coverage if the covered customer ceases to have active service related to the use of portable electronics with the vendor or if the covered customer exhausts the aggregate limit of liability under the policy and the insurer sends notice of termination within 15 business days after exhaustion of the limit.

- Entitle a covered customer for reinstatement up to 12 months after the date of exhaustion of the coverage limit if a customer requests a reinstatement of portable electronics insurance coverage.

- Require a vendor, if terminating a policy, to give a covered customer written notice by certificate of mail at least 45 days before the termination date. Exempt a vendor from the 45-day notice of termination if the vendor is informed that the covered customer has obtained substantially similar alternative coverage from another insurer without lapse of coverage.

Effective Date: ***January 1, 2010***

HOUSE BILL 899 (Chapter 617) / SENATE BILL 863 (Chapter 616) – Workers' Compensation – Death Benefits for Partially Dependent Individuals – Payment

- Increase the maximum workers' compensation payment to partially dependent or partially self-supporting individuals from $60,000 to $75,000 for claims filed for death benefits on or after September 1, 2007.

- Require the Workers' Compensation Commission (WCC) to conduct a study on statutory provisions related to death benefit payments to individuals dependent on a covered employee.

- Require the study to determine legislative changes that would provide fair and equitable benefits to wholly dependent individuals and partially dependent individuals and provide for coordination among all of the death benefit provisions.

- Require the WCC to report its findings and recommendations to the Senate Finance Committee and the House Economic Matters Committee by December 1, 2009.

Effective Date: ***July 1, 2009***

HOUSE BILL 1135 (Chapter 709) – Maryland-National Capital Park and Planning Commission – Workers' Compensation – Lyme Disease Presumption MC/PG 103-09

- Specifies that an employee, other than a police officer, of the Maryland-National Capital Park and Planning Commission who suffers from Lyme disease is presumed to have a compensable occupational disease if the employee did not have the disease before being assigned to work regularly in an outdoor wooded environment and meets other specified criteria.

Effective Date: ***October 1, 2009***

Termination Date: ***September 30, 2015***

SENATE BILL 85 (Chapter 23) – Insurance – Notice of Cancellation or Nonrenewal – Mailing Address

- Requires insurers that provide personal insurance and commercial insurance to send notices of binder or policy cancellation or nonrenewal to the last known address of the named insured.

Effective Date: ***October 1, 2009***

SENATE BILL 161 (Chapter 204) – Injured Workers' Insurance Fund – Board – Term Limits

- Specifies that a member of the board of the Injured Workers' Insurance Fund may not serve for more than either two full terms or a total of 10 years.

Effective Date: ***October 1, 2009***

SENATE BILL 959 (Chapter 336) – Injured Workers' Insurance Fund – Regulation and Status

- Specifies that, with certain exceptions, the Injured Workers' Insurance Fund (IWIF) is subject to the same insurance law requirements as any authorized domestic workers' compensation insurer in the State.

- Requires IWIF to register with the Insurance Commissioner as a third-party administrator (TPA) if it operates as an administrator as defined in § 8-301 of the Insurance Article.

- Requires IWIF to serve as a competitive insurer in the marketplace for workers' compensation insurance, guarantee the availability of such insurance in the State, serve as the insurer of last resort, and engage only in the business of workers' compensation insurance.

- Requires the Insurance Commissioner to examine IWIF at least once every five years to determine whether IWIF's rate making practices produce actuarially sound rates and are not excessive, inadequate, or unfairly discriminatory.

Effective Date: ***October 1, 2009***

OTHER

HOUSE BILL 142 (Chapter 372) – Insurance – Antifraud Plans

- Extends to third-party administrators the requirement to create and file with the Insurance Commissioner an insurance antifraud plan that includes specific procedures to prevent and report insurance fraud and facilitate prosecution of insurance fraud cases.

- Provides that as part of an antifraud plan authorized insurers may require in writing that individuals receiving disability benefits periodically affirm that they remain entitled to the benefits and have had no change in the condition entitling them to the benefits.

- Requires an insurer that requires affirmation to disclose to the individual receiving benefits that knowingly and willfully providing false information or knowingly and willfully failing to provide information is a crime subject to a fine and imprisonment.

Effective Date: ***October 1, 2009***

HOUSE BILL 160 (Chapter 133) – Insurance – Fraudulent Acts – Insurance Producers and Adjusters

- Prohibits a person from representing oneself to be an adviser, bail bondsman, public adjuster, vehicle damage adjuster and appraiser, or motor vehicle rental company that provides insurance coverage unless the person has obtained the appropriate license or approval from the MIA.

Effective Date: ***October 1, 2009***

HOUSE BILL 246 (Chapter 572) / SENATE BILL 616 (Chapter 571) – Insurance Producers – Continuing Education – Funeral Directors and Morticians

- Prohibit the Insurance Commissioner from requiring an insurance producer to receive more than 16 hours of continuing education per renewal period if the insurance producer is also a licensed funeral director or licensed mortician who:

  (1) sells only life insurance policies or annuity contracts that fund a pre-need contract and

  (2) is not a viatical settlement broker.

Effective Date: ***October 1, 2009***

SENATE BILL 8 (Chapter 9) – Insurance – Unfair and Deceptive Practices – Limit on Offer, Promise, or Gift of Valuable Consideration Not Specified in a Contract or Policy

- Increases from $10 to $25 the limit on the value of educational materials, promotional items, or merchandise that an insurer may give to a person not specified in an annuity contract or an insurance contract or policy.

Effective Date: ***October 1, 2009***

SENATE BILL 86 (Chapter 361) – <u>Title Insurance Producers – Regulation and Requirements</u>

- Provides that only a licensed title insurance producer may exercise control over trust money, with exceptions for trust money entrusted to law firms or title insurers.

- Increases the amount of the fidelity bond and the amount of the blanket surety bond or letter of credit that title insurers must maintain as a condition of licensure from $100,000 to $150,000. The increased amounts apply to title insurance producer licenses issued or renewed after October 1, 2009.

- Requires the Commission to Study the Title Insurance Industry in Maryland to review the adequacy of the bonding and letter of credit requirements and include its findings in its final report to the Governor and the General Assembly.

Effective Date: ***June 1, 2009***

SENATE BILL 751 (Chapter 97) – <u>Insurance – Slavery Era Insurance Policies – Reporting</u>

- Requires an insurer authorized to do business in the State to submit a report on slavery era insurance policies to the Insurance Commissioner by October 1, 2011.

- Defines a "slaveholder insurance policy" as a policy issued to or for the benefit of a slaveholder that insured against a slave's injury or death.

- Requires the report to include information in the records of the insurer about each slaveholder insurance policy issued in the State by the insurer, or the insurer's predecessor, during the slavery era (years prior to 1865).

- Requires the insurer to provide a copy of each document in the insurer's records that relates to the information.

- Requires the Insurance Commissioner to issue a report on the information and submit the report to the Governor and the General Assembly by April 1, 2012.

- Requires copies of the report to be made available to the public, published on MIA's web site, and maintained at the law library of the University of Maryland School of Law.

Effective Date: ***October 1, 2009***