



Legislation, Regulations & Bulletins



INSURANCE LEGISLATION

2000 Session of the Maryland General Assembly

Health

SENATE BILL 52 (Chapter 31) - Health Insurance - Dental Plan Organizations

- Requires a dental plan organization (DPO) to have and maintain at all times a surplus equal to the greater of:
 - (1) \$50,000; or
 - (2) 2% of the organization's annual gross premium income, up to a maximum of the required capital and surplus of a stock insurer under § 4-103 of the Insurance Article.
- Requires, with one exception, a DPO to deposit with the Commissioner or with any organization or trustee acceptable to the Commissioner cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to \$25,000 plus 25% of the surplus required in § 14-404(A) of the Insurance Article:

The deposit shall not be required to exceed \$100,000.

The deposit shall not be required of a DPO that does not have any enrollees, as determined by the Commissioner, so long as the DPO:

- 1) held a certificate of authority as of January 1, 2000;
- 2) maintains a current certificate of authority; and
- 3) complies with all applicable laws and regulations as determined by the Commissioner

Effective date: October 1, 2000

SENATE BILL 53 (Chapter 32) - Maryland Health Insurance Portability and Accountability Act - Market Reforms

- Deletes from existing law a provision (§ 15-1208(c) of the Insurance Article) that permits certain plans to impose a waiting period or surcharge on employees if a preexisting condition provision is not imposed on enrollees.

- Defines "special enrollment period" to mean a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.
- Requires a carrier to provide special enrollment periods as described in § 15-1201.1 of the Insurance Article.
- Requires all small employer health benefit plans to provide a special enrollment period during which the following individuals may be enrolled:
 - (1) An individual who becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption;
 - (2) An eligible employee who acquires a new dependent through marriage, birth, adoption, or placement for adoption; and
 - (3) The spouse of an eligible employee at the birth or adoption of a child, provided the spouse is otherwise eligible for coverage.
- Requires a carrier, under certain circumstances (§ 15-1208.1(B) and § 15-1406.1(C) of the Insurance Article), to allow an employee or dependent who is eligible, but not enrolled, for coverage under the employer's health benefit plan to enroll for coverage.
- Establishes, under § 15-1208.1(F) and § 15-1406.1(F) of the Insurance Article, when coverage shall become effective if an individual enrolls in the first 31 days of the special enrollment period as provided for in Title 15 of the Insurance Article.
- Chapter 32, under § 15-1212(D) of the Insurance Article, requires a carrier to provide notice of nonrenewal of a health benefit plan for all small employers in the State at least 90 days before the date of nonrenewal to the Commissioner and each affected employer and enrolled employee.
- Chapter 32 expands the existing definition of "eligible individual" under § 15-301 of the Insurance Article to also mean an individual who does not have coverage under a health benefit plan.

Effective date: July 1, 2000

SENATE BILL 274 (Chapter 248) - Health Insurance - Retroactive Denial of Reimbursement to Health Care Providers

- Defines "reimbursement" to mean payments made to a health care provider by a carrier on either a fee-for-service, capitated or premium basis.
- Prohibits a carrier from retroactively denying reimbursement or attempting in any manner to retroactively collect reimbursement already paid to a health care provider.
- Limits a carrier's ability to retroactively deny reimbursement to a health care provider to certain circumstances except when:

- (i) the information submitted to the carrier was fraudulent;
 - (ii) the information submitted to the carrier was improperly coded and the carrier has provided to the health care provider sufficient information regarding the coding guidelines used by the carrier in accordance with § 15-1008(E)(1)(ii) of the Insurance Article; or
 - (iii) the claim submitted to the carrier was a duplicate claim.
- Applies to retroactive denials of reimbursement made on or after October 1, 2000.

Effective date: October 1, 2000

SENATE BILL 328 (Chapter 519) - Health Care Credentialing Study

- Requires the Schaefer Center for Public Policy at the University of Baltimore to study and review Federal and State law and hospital policies, procedures, and requirements related to credentialing to ensure that there is adequate opportunity for redress of the complaints of physicians, nurse anesthetists, nurse midwives, and social workers relating to exclusion by hospitals and credentialing organizations.
- Requires the Schaefer Center for Public Policy to submit a report on its findings and recommendations to the Governor, the General Assembly and the Legislative Policy Committee within 60 days of completion of the study.

Effective date: June 1, 2000 for a period of 6 months, and at the end of November 30, 2000, this Act shall no longer be in effect.

SENATE BILL 371 (Chapter 270) - Medical Records - Confidentiality

- Prohibits the sale, rental, or barter of any medical record except as provided for in § 4-302 of the Health - General Article.
- Requires payors that accept claims originating in this State from medical care electronic claims clearinghouses to accept claims only from medical care electronic claims clearinghouses that are:
 - (1) accredited by the electronic health care network accreditation commission; or
 - (2) certified by the Maryland Health Care Commission.
- Requires the Maryland Health Care Commission to adopt regulations to implement certification of medical care electronic claims clearinghouses.
- Defines "personal note" and exempts a personal note from the definition of medical record.

- Authorizes the disclosure of a medical record under certain circumstances.
- Establishes a State Advisory Council on Medical Privacy and Confidentiality.

Effective date: July 1, 2000

SENATE BILL 405 (Chapter 275) - Health Maintenance Organizations - Reimbursement of Non-Contracting Providers

- Requires a HMO or its agent to pay for the provision of a covered service to an enrollee of the HMO by a provider not under written contract with the HMO in accordance with § 19-710.1(b) of the Health - General Article.
- Chapter 275 (§ 19-710.1(b)(ii)(2) of the Health - General Article) requires a HMO to pay the claim submitted by a non-participating provider the greater of:
 - a. 125% of the rate the health maintenance organization pays in the same geographic area, for the same covered service, to a similarly licensed provider under written contract with the HMO; or
 - b. the rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.
- Requires a HMO to disclose, on the request of a health care provider not under written contract with the HMO, the reimbursement rate required under § 19-710.1(b)(1)(II)2 of the Health - General Article.
- Authorizes a health care provider to file a complaint against a HMO with the MIA or by filing a civil action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article for violations of this law.

Effective date: October 1, 2000

SENATE BILL 455 (Chapter 279) - Health Insurance - Notice of Health Care Providers on Carrier's Provider Panel

- Defines "provider panel" to mean the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.
- Requires, under § 15-112(j)(1) of the Insurance Article, a carrier to provide to an enrollee at the time of initial enrollment:
 - (I) a printed list of providers on the carrier's provider panel; and
 - (II) printed information on providers that are no longer accepting new patients.

- Requires, under § 15-112(j)(2) of the Insurance Article, a carrier to make available to prospective enrollees and notify each existing enrollee at the time of renewal about how to obtain certain provider information on the internet and in printed form.
- The information provided in printed form, in accordance with § 15-112(j)(1) and (2) of the Insurance Article, must be updated at least once a year.
- The information provided on the internet, under § 15-112(j)(2) of the Insurance Article, must be updated at least once every 15 days.

Effective date: October 1, 2000

SENATE BILL 855 (Chapter 565) - Senior Assistance - Short-Term Prescription Drug Subsidy Plan

- Establishes Subtitle 6. Short-Term Prescription Drug Subsidy Plan in the Health - General Article.
- Requires, under § 15-605 of the Health - General Article, the Secretary of DHMH to adopt regulations to implement this law.
- Defines terms under § 15-601 of the Health - General Article.
- Chapter 565 (§ 15-602 of the Health - General Article) requires a carrier that is required to provide the benefits mandated under Title 15, Subtitle 6 of the Health - General Article to agree to certain terms of participation.
- Chapter 565 (§ 15-603 of the Health - General Article) establishes certain requirements with respect to cost-sharing and participation.
- Chapter 565 (§ 15-604 of the Health - General Article) establishes a Short-Term Prescription Drug Subsidy Plan Fund, which contains the assessment against carriers made under § 15-606(C) of the Insurance Article.
- Chapter 565 (§ 15-605 of the Health - General Article) requires, on or before June 30 of each year, the Secretary, HSCRC, and the MIA to submit a joint report to the Governor and the General Assembly.
- The report required under § 15-605 of the Health - General Article must include a summary of the program activities for the year and any recommendations for consideration by the General Assembly.
- § 6-101(b) of the Insurance Article, which lists certain persons that are not subject to taxation under the Insurance Article, was expanded to include the "Plan" created under Title 15, Subtitle 6 of the Health - General Article.
- § 15-606(C) of the Insurance Article:

- (1) prohibits a carrier from receiving the approved purchaser differential unless the carrier contributes to the "Plan"; and
 - (2) establishes the formula for determining the amount required to be contributed by a carrier to the "Fund".
- Prohibits the HSCRC from taking steps to eliminate or adjust the differential in hospital rates allowed for exchange for participation in the SAAC under § 15-606 of the Insurance Article as those rates were in effect on January 1, 2000 until the later of the termination of the "Plan" or the end of June 30, 2002.
 - Requires the Secretary of DHMH to study the cost of providing access to managed care for Medicare + Choice-eligible individuals residing in urban, suburban, and rural areas throughout the State. The results of the study must be reported to the Governor and the General Assembly on or before January 1, 2001.

Effective date: June 1, 2000

SENATE BILL 883 (Chapter 320) - Health Insurance - Task Force to Study the Non-Group Health Insurance Market - Repeal

- Repeals the Task Force to Study the Non-Group Health Insurance Market.

Effective date: June 1, 2000

SENATE BILL 903 (Chapter 569) - Contracts between Health Maintenance Organizations and Subscribers or Groups of Subscribers - Subrogation Provisions

- Authorizes (§ 19-713.1 of the Health - General Article) contracts between health maintenance organizations (HMOs) and subscribers to contain a provision that allows the HMO, under certain circumstances, to be subrogated to a cause of action that a subscriber has against another person.
- Prohibits (§ 19-713.1(E) of the Health - General Article) contracts between HMOs and subscribers from containing a provision that allows the HMO to recover any payments made to a subscriber under a personal injury protection policy.
- Requires (§ 19-713 of the Health - General Article) a HMO that includes a subrogation provision in its contract as authorized to:
 - (1) use in its rating methodology an adjustment that reflects the subrogation; and
 - (2) identify in its rate filing with the MIA, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

Effective date: June 1, 2000

HOUSE BILL 2 (Chapter 16) / SENATE BILL 863 (Chapter 15) - Maryland Health Programs Expansion Act of 2000

- Establishes the Maryland Children's Health Program.
- For individuals whose family income is at or below 200 percent of the Federal poverty guidelines, may be eligible for the program under Title 15, Subtitle 1 (CHIPS) of the Health - General Article.
- For eligible individuals whose family income is above 200 percent, but at or below 300 percent of the Federal poverty guidelines, certain benefits are available under § 15-301.1 of the Health - General Article.
- The law establishes the MCHP Private Option Plan.
- DHMH has regulatory oversight of the MCHP Private Option Plan and must adopt regulations to implement the law.
- Exempts certain individuals from § 15-1208(b)(2) of the Health - General Article if the individual is eligible for enrollment under the MCHP Private Option Plan if a request for enrollment is made within 30 days after becoming eligible.
- Subjects the MCHP Private Option Plan to all of the provisions of Title 15, Subtitle 12 of the Insurance Article that are applicable to the Standard Plan.
- Requires a carrier (§ 15-1208(E) of the Insurance Article) to allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if the employee or dependent requests enrollment within 30 days of eligibility.

Effective date: July 1, 2001

HOUSE BILL 5 (Chapter 323) - Health Insurance - Health Maintenance Organizations - Responsibility for and Regulation of Downstream Risk

- Applies to HMOs and MCOs (§ 15-102.3 of the Health - General Article).
- Clarifies existing law (§ 19-712 of the Health - General Article) to ensure that the responsibility of a HMO for claims or payments for health care services provided to the HMOs' members through an administrative service provider contract:
 - (1) is not limited by the amount in the segregated fund;
 - (2) exists irrespective of the insolvency or other inability or failure of a contracting provider;
 - (3) exists irrespective of the delegation or further subcontracting of health care services by a contracting provider to an external provider;

(4) may not be altered by contract; and

(5) applies to all health care services, unless preempted by federal law.

- Does not apply to certain contracts under certain circumstances (§ 19-713.2(B) of the Health - General Article).
- Amends § 19-713.2 of the Health - General Article, including:
 - (D) Requires the contracting provider to provide the HMO with:
 - (1) monthly reports within 30 days of the end of the month reported that identify payments made or owed to external providers;
 - (2) a current annual financial statement of the contracting provider each year, within 90 days of the end of the year reported; and
 - (3) requires the HMO to establish and maintain a segregated fund in a form and in an amount approved by the Commissioner.
 - (F) Clarifies that the Fund is not an asset of the contracting provider.
 - (I) Requires a HMO to provide the Commissioner with results of each quarterly review.
- Requires a contracting provider to register with the Commissioner.
- Authorizes the Commissioner to charge a registration fee.
- Authorizes the Commissioner to adopt regulations.
- Requires the Commissioner, in consultation with the Secretary of DHMH, to establish and adopt by regulation a methodology to be used in the annual report that insures a clear separation of all medical and administrative expenses whether incurred directly or through a sub-contractor.
- Authorizes the Commissioner to conduct an examination to insure that an annual report required by this law is accurate.

Effective date: June 1, 2000

HOUSE BILL 6 (Chapter 92) - Health Insurance - Coverage of Habilitative Services for Children

- Applies to:

- (1) Insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- Requires an entity (§ 15-835 of the Insurance Article) to provide coverage of habilitative services for children under the age of 19 years.
 - Allows an entity to provide the required coverage through a managed care system.
 - Permits an entity to not provide reimbursement for habilitative services delivered through early intervention or school services.
 - Requires an entity to provide notice annually to its insureds and enrollees about the coverage required under this section.

Effective date: October 1, 2000

HOUSE BILL 22 (Chapter 326) - Health Benefit Plans - Coverage for Hair Protheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer

- Applies to:
 - (1) Insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- § 15-835 of the Insurance Article requires an entity subject to this law to provide, for an enrollee or insured whose hair loss results from chemotherapy or radiation treatment for cancer, coverage for one hair prosthesis.
- The cost of a hair prosthesis required by § 15-835 of the Insurance Article may not exceed \$350.
- To be covered under this law, a hair prosthesis must be prescribed by the oncologist in attendance.

Effective date: October 1, 2000

HOUSE BILL 59 (Chapter 329) - Health Insurance - Adverse Decisions and Grievance Decisions - Notification Requirements

- Requires a carrier subject to Title 15, Subtitle 10A of the Insurance Article to provide notice, in writing, to a member and the member's health care provider, of an adverse decision within 5 days of the adverse decision.
- The notice required in § 15-10A-02 of the Insurance Article must provide certain information to the member and health care provider.
- Eliminates a requirement (§ 15-10A-02(f) of the Insurance Article) that a carrier send a notice upon the filing of a grievance by a member or a member's health care provider.

Effective date: October 1, 2000

HOUSE BILL 92 (Chapter 331) - Health Insurance - Risk Based Capital Standards for Insurers and Managed Care Organizations

- Requires all HMOs to comply with the RBC standards in the same manner as health insurers under Title 4, Subtitle 3 of the Insurance Article.
- Requires each MCO to comply with the RBC standards in accordance with the regulations adopted by the Commissioner under § 4-311 of the Insurance Article.
- Requires the Commissioner, in consultation with the Secretary of DHMH, to adopt regulations that apply appropriate RBC standards to MCOs no later than July 1, 2001.

Effective date: July 1, 2000

HOUSE BILL 304 (Chapter 355) - Health Insurance - Preauthorized Health Care Services - Denials of Reimbursement by Carriers

- Prohibits a carrier (§ 19-706 of the Health - General Article and § 15-1009 of the Insurance Article) from denying reimbursement to a health care provider for a preauthorized or approved service delivered to the patient unless:
 - (1) The information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;
 - (2) Critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;
 - (3) A planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider;
or
 - (4) On the date the preauthorized or approved service was delivered:

- (I) The patient was not covered by the carrier;
 - (II) The carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the internet; and
 - (III) According to the verification system, the patient was not covered by the carrier.
- Requires a carrier to pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15-1005 and 15-1008 of the Insurance Article.

Effective date: June 1, 2000

HOUSE BILL 316 (Chapter 359) - Health Insurance Carriers - Standing Referral to Obstetrician for Pregnancy

- § 15-830 of the Insurance Article requires a member who is pregnant to receive a standing referral to an obstetrician.
- After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

Effective date: October 1, 2000

HOUSE BILL 350 (Chapter 283) / SENATE BILL 516 (Chapter 282) - Health Insurance - Coverage for In Vitro Fertilization

- Applies to:
 - (a) Insurers and nonprofit health benefit service plans that provide hospital, medical or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies that are issued or delivered in the State; and
 - (b) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- Prohibits an entity subject to § 15-810 of the Insurance Article that provides pregnancy-related benefits from excluding benefits for all outpatient expenses arising from in vitro fertilization procedures performed on the policyholder or subscriber or dependent spouse of the policyholder or subscriber.
- § 15-810(b)(2) of the Insurance Article requires the benefits under § 15-180(b) of the Insurance Article to be provided:

(I) For insurers and nonprofit health service plans, to the same extent as the benefits provided for other pregnancy-related procedures; and

(II) For HMOs, to the same extent as the benefits provided for other infertility services.

- § 15-810(c) of the Insurance Article establishes under what circumstances § 15-810(b) of the Insurance Article shall apply.
- § 15-810(D) of the Insurance Article authorizes an entity subject to § 15-810 of the Insurance Article to limit coverage of the required benefits to three in vitro fertilization attempts per live birth not to exceed a maximum lifetime benefit of \$100,000.
- § 15-810(E) of the Insurance Article authorizes, upon the request of the religious organization, the exclusion of the benefits required under § 15-810 of the Insurance Article from a contract with a religious organization if the coverage conflicts with the bona fide religious beliefs and practices of the religious organization.

Effective date: October 1, 2000

HOUSE BILL 405 (Chapter 371) - Health Insurance - Internal Appeal and Grievance Processes

- Requires a carrier subject to Title 15, Subtitle 10A of the Insurance Article to provide notice, in writing, to a member and the member's health care provider, of an adverse decision within 5 days of the adverse decision.
- The notice required in § 15-10A-02 of the Insurance Article must provide certain information to the member and health care provider.
- Eliminates a requirement that a carrier send a notice upon the filing of a grievance by a member or a member's health care provider.
- Requires a carrier to establish an internal appeal process for use by its members and health care providers to dispute coverage decisions made by the carrier under Title 15, Subtitle 10D of the Insurance Article.
- Requires a carrier to render a final decision, in writing, to a member, and a health care provider acting on behalf of the member, within 60 working days after the date on which the appeal is filed.
- Requires exhaustion of a carrier's internal appeal process by a member, or a health care provider acting on behalf of a member, unless the coverage decision involves an urgent medical condition for which care has not been rendered.
- Requires the Commissioner to define, by regulation, an urgent medical condition for the purpose of allowing a member, or health care provider acting on behalf of the member, to bypass a carrier's internal appeal process.

- Requires a carrier, within 30 days after a coverage decision has been made, to send a written notice of the coverage decision to the member, and in the case of a HMO, the treating health care provider.
- Requires the notice of the coverage decision (§ 15-10D-02(E) of the Insurance Article) to:
 - (I) state in detail in clear, understandable language, the specific factual bases for the carrier's decision; and
 - (II) include the following information:
 1. That the member, or a health care provider acting on behalf of the member, has a right to file an appeal with the carrier;
 2. That the member, or a health care provider acting on behalf of the member, may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;
 3. The Commissioner's address, telephone number, and facsimile number;
 4. That the Health Advocacy Unit is available to assist the member in both mediating and filing an appeal under the carrier's internal appeal process;
 5. The address, telephone number, facsimile number, and e-mail address of the Health Advocacy Unit.
- Requires the carrier, within 30 days after the appeal decision has been made, to send to the member, and the health care provider acting on behalf of the member, a written notice of the appeal decision (§ 15-10D-02(F) of the Insurance Article). The notice must:
 - (I) state in detail in clear, understandable language the specific factual bases for the carrier's decision;
 - (II) include the following information:
 1. That the member or the health care provider acting on behalf of the member, has a right to file a complaint with the Commissioner within 60 working days after receipt of a carrier's appeal decision; and
 2. The Commissioner's address, telephone number, and facsimile number.
- The Commissioner may require consent from the member authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee (§ 15-10D-02(G) of the Insurance Article).
- Establishes that during the review of a complaint by the Commissioner or the Commissioner's designee, a carrier has the burden of persuasion that its coverage decision or appeal decision is correct (§ 15-10D-02(A) of the Insurance Article).

- Requires the Commissioner to:
 - (1) make and issue in writing a final decision on all complaints filed with the Commissioner that are within the Commissioner's jurisdiction; and
 - (2) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under Title 15, Subtitle 10D of the Insurance Article.
- Authorizes the Commissioner to take certain action against a carrier for a violation of Title 15, Subtitle 10D of the Insurance Article.
- Authorizes the Commissioner to adopt regulations to carry out the provisions of Title 15, Subtitle 10D of the Insurance Article.

Effective date: October 1, 2000

HOUSE BILL 412 (Chapter 123) - Health Insurance - Private Review Agents

- Prohibits an entity from acting as a private review agent without holding a certificate of registration pursuant to Title 15, Subtitle 10B of the Insurance Article.
- Prohibits an entity from using a private review agent that does not hold a certificate issued under Title 15, Subtitle 10B of the Insurance Article.
- Authorizes the Commissioner to impose penalties on an entity that violates § 15-1001 of the Insurance Article.
- Defines "private review agent" to include a third party that pays for, provides, or administers health care services to citizens of this State.
- Requires a private review agent, at least 10 days before the private review agent requires specific criteria and standards to be used in conducting utilization review of proposed or delivered services in which there are no existing criteria or standards, to submit the criteria and standards to the Commissioner.
- Requires a private review agent to advise the Commissioner in writing of certain changes in, including:
 - (1) ownership, medical director, chief executive officer within 30 days of the change;
 - (2) the name, address, or telephone number of the private review agent within 30 days of the change; or
 - (3) the private review agent's scope of responsibility under a contract.

- Requires a private review agent that has an appeal and grievance process to contact it in accordance with §§ 15-10A-02 through 15-10A-05 of the Insurance Article.
- Authorizes the Commissioner to:
 - (1) deny, suspend, or revoke the certificate of registration;
 - (2) issue an order to cease and desist from acting as a private review agent;
 - (3) require a private review agent to make restitution to a patient who has suffered actual economic damage because of the violation; and
 - (4) impose an administrative penalty of up to \$5,000 for each violation of the private review agent law.
- Requires a private review agent to advise the Commissioner, in writing, of its intention to withdraw its certificate within 60 days of intention to cease operations as a private review agent.
- Requires a private review agent to submit its certificate to the Commissioner within 30 days after the date that the private review agent ceased operations.

Effective date: January 1, 2001

HOUSE BILL 559 (Chapter 254) / SENATE BILL 295 (Chapter 253) - Health Insurance - Requirements for Providers to Serve on Provider Panels

- Prohibits a carrier that offers coverage for health care services through one or more health benefit plans or contracts with providers to offer health care services through one or more provider panels from requiring, as a condition of participation or continuation on a provider panel for one health benefit plan of a carrier, to serve also on a provider panel of another health benefit plan of the carrier.
- A carrier that offers health care services as a MCO as defined under § 15-101(F) of the Health - General Article may require a provider, as a condition of participation on a provider panel for one or more health benefit plans of the carrier, to serve on a provider panel of the MCO.
- Requires a provider who elects to terminate participation on the provider panel of a health benefit plan to:
 - (i) notify the carrier at least 90 days before the date of termination; and
 - (ii) for at least 90 days after the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services prior to the notice of termination.

Effective date: October 1, 2000

HOUSE BILL 649 (Chapter 400) - Health Insurance - Small Group Market - Eligibility Requirements

- Alters certain requirements (§ 15-1201 of the Insurance Article) by which a person is considered a small employer, including:
 - (b)(1)(i) on at least 50% of its working days during the preceding calendar QUARTER, employed at least 2 but not more than 50 eligible employees, the majority of whom are employed in the State;
 - (c) an individual must work AND reside in the State.
- Eliminates a provision (§ 15-1203(f) of the Insurance Article) to be considered a small employer if:
 - (1) All but one of its eligible employees are covered under another public or private health benefit plan or other health benefit arrangement; and
 - (2) Only one of its eligible employees is not covered under any public or private health benefit plan or other health benefit arrangement.
- Requires the Maryland Health Care Commission, in consultation with the MIA, carriers, small employers and agents and brokers, to report to the legislature on the effect of group size in the small group insurance market on the HMO and PPO delivery systems of each prominent carrier in the small group market.
- Requires a carrier to renew the health benefit plan of a small employer that has coverage under Title 15, Subtitle 12 of the Insurance Article on May 31, 2000, for as long as the small employer meets the definition of a small employer in effect on the date the small employer applied for the coverage.

Effective date: June 1, 2000

HOUSE BILL 669 (Chapter 402) - Health Insurance - Access to Obstetric and Gynecological Services

- Applies to:
 - (1) Insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

- Expands existing law (§ 15-816 of the Insurance Article and § 19-706 of the Health - General Article) to require an entity subject to this law to allow a woman to receive medically necessary, routine obstetric and gynecological care from an in-network, certified nurse midwife or any other in-network provider authorized under the Health Occupations Article to provide obstetric and gynecological services without first requiring the woman to visit a primary care provider.
- A certified nurse midwife or other non-physician provider authorized under the Health Occupations Article to provide obstetric and gynecological services shall consult with an ob/gyn with whom the certified nurse midwife or other provider has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered under Chapter 402.

Effective date: October 1, 2000

HOUSE BILL 762 (Chapter 410) - Health Insurance - Uniform Claims Forms

- Requires the Commissioner (§ 15-1003 of the Insurance Article) to adopt by regulation:
 - (1) (I) A definition of a clean claim, including:
 1. The essential data elements that must be completed on the uniform claims form; and
 2. Uniform standards for attachments to the uniform claims form.
 - (II) Permissible categories of disputed claims for which additional information may be requested under §§ 15-1004(C) and 15-1005(C) of this Subtitle; and
 - (III) Standards for determining when a claim is considered received for reimbursement.
- (2) In adopting the regulations required under paragraph (1)(I) of this Subsection, the Commissioner shall consider:
 - (I) Standards for attachments required by the Federal Health Care Financing Administration for the Medicare program;
 - (II) Standards used by insurance carriers, nonprofit health service plans, and health maintenance organizations in the State; and
 - (III) Federal regulations adopted under the Health Insurance Portability and Accountability Act.
- Requires the regulations to include standards for clean claims for services rendered in a hospital emergency facility.
- Requires the Commissioner to publish the required regulations on or before January 1, 2001.

- Requires the Commissioner to convene a State Uniform Billing Committee comprised of representatives of the affected parties to advise and assist in the development of the regulations.
- Allows an insurer, nonprofit health service plan, or HMO, if the legitimacy or appropriateness of a health care service is disputed, to request additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the insured.
- Requires insurers, nonprofit health service plans, and HMOs (§ 15-1004(D)(1) of the Insurance Article) to provide and update, as appropriate, all contracting providers and any other provider on request, with a manual or other document that sets forth the claims filing procedures.
- If an insurer, nonprofit health service plan, or HMO (§ 15-1004(D)(2) of the Insurance Article) has delegated its claims processing function to a third party, the delegation agreement:
 - (I) Shall require the claims processing entity to comply with the requirements of this Subtitle; and
 - (II) May not be construed to limit the responsibility of the insurer, nonprofit health service plan, or health maintenance organization to comply with the requirements of this Subtitle.
- Requires an entity subject to this law (§ 15-1005(E)(1) of the Insurance Article), that provides notice under § 15-1005(C)(2)(I) of the Insurance Article, to pay any undisputed portion of a claim within 30 days of receipt of the claim.
- Requires an entity, under § 15-1005(E)(2) of the Insurance Article, that provides notice under § 15-1005(C)(2)(II) of the Insurance Article to:
 - (I) Pay the claim in accordance with this section; or
 - (II) Send a notice of receipt and status of the claim that states:
 1. That the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;
 2. That, in accordance with § 15-1003(D)(1)(II) of this Subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or
 3. That the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.
- Requires an entity (§ 15-1005(E)(3) of the Insurance Article) that provides notice under § 15-1005(C)(2)(III) of the Insurance Article to comply with

§§ 15-1005(C)(1) or (2)(I) of the Insurance Article within 30 days after receipt of the requested additional information.

- Authorizes the Commissioner (§ 15-1005(F) of the Insurance Article) to impose, on an entity that violates this law, the following:
 - (I) A fine not exceeding \$500 for each violation that is arbitrary and capricious, based on all available information; and
 - (II) The penalties prescribed under § 4-113(D) of this article for violations committed with a frequency that indicates a general business practice.

Effective date: June 1, 2000

HOUSE BILL 1016 (Chapter 449) - Health Insurance - Discrimination - Specified Diseases or Diagnoses

- Applies to:
 - (1) Insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- Unless otherwise provided by law, an entity subject to § 29-913 of the Insurance Article or § 19-706 of the Health - General Article may not make benefits under a policy or contract issued or delivered by the entity in the State for the treatment of a specified disease or diagnosis subject to different copayment amounts, coinsurance, deductibles, annual maximum limits, or lifetime maximum limits than those that apply to all other diseases covered under the policy or contract.

Effective date: October 1, 2000

HOUSE BILL 1222 (Chapter 465) - Private Review Agents - Market Conduct Examinations

- Applies the examination provisions of §§ 2-205, 2-207, 2-208 and 2-209 of the Insurance Article to HMOs.
- Requires private review agents to undergo examination by the Commissioner.
- Requires private review agents to pay for the expense of an examination conducted under § 15-108-19 of the Insurance Article.

Note: An emergency bill, therefore, became law on the day that it was signed by the Governor - Effective date: May 11, 2000

Life Insurance

HOUSE BILL 978 (Chapter 660) - Life Insurers - Classes of Reserve Investments

- The bill alters the classes of reserve investments for life insurers, defines certain terms, and generally relates to investments of life insurers.
- Current Maryland law requires insurers to have investments underlying their policyholder obligations in ultra-conservative investments, primarily investments such as Government obligations, corporate bonds and, up to certain limits, dividend-paying stocks. This bill expands the categories of investments that are considered reserve investments.
- Specifically, this bill expands reserve investments for life insurers to include, subject to certain restrictions and limitations, asset-backed securities, real estate investment trusts (REITs), foreign investments, securities lending, repurchase, reverse repurchase and dollar roll transactions (all of which are fully collateralized transactions), and derivative transactions when used for hedging purposes only.
- Amends §§ 5-509 and 5-511 of the Insurance Article.

Effective date: October 1, 2000

HOUSE BILL 979 (Chapter 661) - Insurance - Regulation of Extraordinary Dividends and Distributions

- Alters the definition of "extraordinary dividend" which: 1) alters the circumstances under which a dividend or distribution of cash or property to be made by an insurer or a life insurer to a shareholder is considered extraordinary and subject to prior approval by the Commissioner.
- Clarifies that the law (§ 7-701 of the Insurance Article) applies to life insurers.
- Establishes the manner for determining whether a dividend or distribution is extraordinary (§ 7-706 of the Insurance Article):
 - (1) An insurer that is not a life insurer may carry forward net investment income from 3 calendar years prior to the preceding calendar year that has not already been paid out as dividends;
 - (2) The amount earned forward under paragraph (1) must be computed in a certain manner.
- An insurer that is not a life insurer may pay an extraordinary dividend only out of earned surplus.

Effective date: October 1, 2000

Property and Casualty

SENATE BILL 80 (Chapter 45) - Maryland Automobile Insurance Fund - Motor Vehicle Administration Referrals

- Alters when the Executive Director of MAIF is required to refer an individual to the MVA under certain circumstances (§ 20-518 of the Insurance Article).
- MAIF shall refer the status of an insured's driver's license to the MVA for a determination when the insured, in the last 12-month period, had three or more chargeable accidents under the rules and rate schedules of the Fund filed with the Commissioner involving third-party liability.

Effective date: October 1, 2000

SENATE BILL 307 (Chapter 514) - Motor Vehicle Liability Insurance - Voluntary Cancellation of Policy - Regulations

- Requires the MVA, in consultation with the MIA and industry representatives, to adopt regulations establishing procedures to be used by an insurer to provide timely notification to an insured of the penalties that may be imposed in accordance with § 17-706 of the Transportation Article if the insured fails to renew or replace a policy of motor vehicle liability insurance without surrendering the evidences of registration.
- Amends § 17-104 of the Transportation Article.

Effective date: October 1, 2000

SENATE BILL 598 (Chapter 541) - Insurance Rating Law - Exempt Commercial Policyholders

- Amends § 11-206 of the Insurance Article.
- Defines "exempt commercial policyholder" as a person that:
 - (I) Pays annual aggregate property and casualty premiums for commercial insurance policies issued in the State during the current or preceding calendar year of \$75,000 or more; and
 - (II) Meets any two of the following criteria:
 1. Generates annual revenues or sales in excess of \$10,000,000;

2. Possesses a net worth in excess of \$5,000,000;
 3. Employs at least 25 full-time employees;
 4. Is a nonprofit organization or public body with an annual budget of at least \$10,000,000; or
 5. Is a municipal corporation with a population of at least 15,000.
- Exempts an "exempt commercial policyholder" from the filing requirements of § 11-206 of the Insurance Article.
 - Requires an "exempt commercial policyholder" to certify, in writing, on a form approved by the Commissioner, that the criteria for exemption from form filing requirements have been met.
 - The required certification must include:
 1. specific reference to the optional criteria that the insured has satisfied to qualify as an exempt commercial policyholder;
 2. information required by the Commissioner for the purpose of determining the annual aggregate premiums of the insured for purposes of Paragraph (1)(I) of this subsection; and
 3. an acknowledgment by the insured that the policy form, endorsement, or modification intended for use has not been filed with the Commissioner.
 - Allows the Commissioner to require, by regulation, insurers to provide the MIA with information on the number and types of policies written for "exempt commercial policyholders."
 - Requires an insurer, upon written request of the Commissioner, to file with the Commissioner a form or endorsement issued to an exempt commercial policyholder.
 - Allows the Commissioner, by regulation, to authorize an exempt commercial policyholder to procure coverage under Chapter 541 from an unauthorized insurer in accordance with § 3-306.1 of the Insurance Article.

Effective date: October 1, 2000

SENATE BILL 881 (Chapter 567) - Injured Workers' Insurance Fund - Regulation

- Among other things, Chapter 567 requires the Fund to be a member of the Property and Casualty Insurance Guaranty Corporation.
- Requires the Commissioner to examine the financial condition of the Fund and ensure that the Fund satisfies the solvency standards for a workers' compensation insurer in this State

before the Fund may become a member of the Property and Casualty Insurance Guaranty Corporation.

- Requires the Fund, under § 10-125(A)(1) of the Labor and Employment Article, to be examined by the Insurance Commissioner in accordance with § 2-205 and § 2-207 of the Insurance Article.
- Repeals §§ 10-119 and 10-125 of the Insurance Article.
- Subjects the Fund to Title 4, Subtitle 3; Title 5, Subtitles 1, 2 and 9; and Title 9 of the Insurance Article.
- Authorizes the Commissioner to issue an Order under Title 9 of the Insurance Article.
- Authorizes the Commissioner to take action authorized under § 4-307 and § 4-308 of the Insurance Article relating to RBC standards for insurers.
- Prohibits the Commissioner from issuing an Order that includes a requirement that the Fund increase rates.
- Requires the Commissioner to report to the Board for the Fund on the results of any examination conducted in accordance with § 10-125(A)(1).
- With respect to Title 12, Subtitle 1; Title 27; and Title 19, Subtitle 4 (except for § 19-403), all of the Insurance Article, the Commissioner:
 - (1) may examine or review the Fund for compliance with these provisions;
 - (2) may not take any action to enforce these provisions; and
 - (3) must report to the Board for the Fund the results of any examination or review conducted.
- Applicable statutes include but may not be limited to §§ 10-105 and 10-125 of the Labor and Employment Article.

Effective date: October 1, 2000

HOUSE BILL 413 (Chapter 124) - Insurance - Cancellation of Policies - Required Notice

- Requires insurers to provide an insured with written notice of intention to cancel a policy for nonpayment of premium 10 days before the proposed date of cancellation for nonpayment of premium as required under § 27-605 of the insurance article.
- Notices of intention to cancel subject to § 27-601 must be sent by certificate of mailing.
- Notices of intention to cancel for failure to pay premium subject to § 27-605 must be sent by certificate of mailing.

- Alters the mailing requirement for an insurer to provide an employer with a notice to cancel a workers' compensation policy from registered mail to certified mail (§ 19-406(a) of the Insurance Article).

Effective date: October 1, 2000

HOUSE BILL 1129 (Chapter 460) - Automobile Insurance - Proof of Insurance

- Amends § 12-301 of the Insurance Article.
- Requires an insurer to provide, at the request of the insured or person holding an insurable interest in the subject of the policy:
 - (I) A copy of the automobile insurance policy declarations; or
 - (II) Written proof of the automobile insurance that consists of:
 1. The name and address of the insured and insurer;
 2. A description of the vehicle, including the vehicle identification number, that is the subject of the insurance policy;
 3. A description and the amount, if applicable, of the insurance coverage including applicable deductibles;
 4. The inception and expiration dates of coverage;
 5. The name and address of the person with an insurable interest; and
 6. The premium for the applicable coverage.
- Permits an insurer to require written authorization from the insured before providing proof of insurance.

Effective date: October 1, 2000

HOUSE BILL 1339 (Chapter 693) - Property and Casualty Insurers - Requests for Data by Commissioner

- Allows the Commissioner to request from a property and casualty insurer, by bulletin, data that relates to policies written by the insurer (§ 19-112 of the Insurance Article).
- A request by bulletin must specify:
 - (1) the line of insurance for which the data is being requested; and

(2) the period of time for which the data is requested.

- Requires data requested pursuant to § 19-112 of the Insurance Article to be filed with the Commissioner in a form required by the Commissioner.
- A request by bulletin expires 2 years after the date of the request unless the Commissioner issues another bulletin.
- Requires the Commissioner, at least 15 days prior to granting inspection of company-specific data (§ 10-614 of the State Government Article), to notify the insurer that supplied the data:

(1) that the Commissioner has received an application to inspect data filed by the insurer;

(2) which data the Commissioner intends to disclose in granting the application; and

(3) that, within 7 days of receipt of the notice, the insurer has the opportunity to provide any reason why the data is confidential commercial data or is otherwise protected from disclosure under the Public Information Act.

Effective date: October 1, 2000

Miscellaneous

SENATE BILL 199 (Chapter 4) - Public Records - Privacy Policies and Data Security

- Chapter 4 prohibits the creation of "personal records" by certain entities unless the need for the information has been clearly established by the unit collecting the records.
- Chapter 4 requires personal information collected for personal records:
 - (I) to be appropriate and relevant to the purposes for which it is collected;
 - (II) to be accurate and current to the greatest extent practicable; and
 - (III) not to be obtained by fraudulent means.
- § 10-624(C) of the State Government Article, which applies only to units of state government, also requires an official custodian who keeps personal records to collect personal information from the person in interest.
- An official custodian who requests personal information for personal records is required to provide certain information to each person in interest from whom personal information is collected.

- Requires each unit of state government to post its privacy policies with regard to the collection of personal information on its internet web site.
- The following personal records are exempt from the requirements of Chapter 4:
 - (I) Information pertaining to the enforcement of criminal laws or the administration of the penal system;
 - (II) Information contained in investigative materials kept for the purpose of investigating a specific violation of state law and maintained by a state agency whose principal function may be other than law enforcement;
 - (III) Information contained in public records which are accepted by the state archivist for deposit in the Maryland Hall of Records;
 - (IV) Information gathered as part of formal research projects previously reviewed and approved by federally mandated institutional review boards; and
 - (V) Any other personal records exempted by regulations adopted by the Secretary of Budget and Management, based on the recommendation of the Chief of Information Technology.
- Requires the Secretary of Budget and Management to report on October 1 of each year to the General Assembly on the personal records exempted by regulations under § 10-624(C)(5)(V) of the State Government Article.
- Applicable statutes include but may not be limited to §§ 10-624 and 10-633 of the State Government Article.

Effective date: October 1, 2000

**SENATE BILL 244 (Chapter 357) / HOUSE BILL 310 (Chapter 356) -
Commuter Benefits Act of 2000**

- Among other things, allows a credit against the State insurance premium tax for certain employer costs associated with providing employees with certain commuter benefits.
- Applicable statutes include but may not be limited to § 2-901 of the Environment Article and § 10-715 of the Tax - General Article.

Effective date: July 1, 2000

**HOUSE BILL 85 (Chapter 330) - Civil Actions - Disclosure of Business
 Address**

- Requires an insurer or a person, on written request of a party to a certain action, that has a self-insurance plan to provide to the party the defendant's last-known name and business address, if known (§ 6-311 of the Courts and Judicial Proceedings Article).

Effective date: October 1, 2000

HOUSE BILL 119 (Chapter 101) - Mutual Insurance Holding Company Act

- Allows a mutual insurer, under certain circumstances, to reorganize as a stock insurer and establish a mutual insurance holding company (§ 3-121.1 of the Insurance Article).
- An insurer must submit, for approval by the Commissioner, a plan of reorganization.
- Each policyholder of the reorganized stock must be a member of the mutual insurance holding company.
- Allows a mutual insurance holding company to become a stock insurer in accordance with § 3-121.1.
- Requires the Commissioner to approve a plan of reorganization that complies with the requirements of § 3-121.1 of the Insurance Article and is equitable to the mutual insurer's members.
- Allows the Commissioner, in approving a plan of reorganization, to impose additional conditions and requirements that the Commissioner determines are necessary to achieve the purposes of § 3-121.1 of the Insurance Article.
- Allows the Commissioner to adopt regulations for the enforcement of § 3-121.1 of the Insurance Article.

Effective date: June 1, 2000

HOUSE BILL 344 (Chapter 119) - Insurance Agents and Brokers - Records

- Requires the Commissioner (§ 10-128.1 of the Insurance Article) to adopt regulations that establish the minimum length of time for which and the manner in which an independent agent or broker is required to maintain records of insurance transactions conducted by the agent or broker.

Regulations must be developed on or before October 1, 2000.

Effective date: October 1, 2000

INSURANCE LEGISLATION

2001 Session of the Maryland General Assembly

Agent Licensing

SENATE BILL 576 (Chapter 731) - Insurance Producer Licensing Act

Among other things, SB 576 accomplishes:

Reciprocity

- Deletes the bond requirement for non-residents;
- Deletes the requirement that a non-resident agent have an appointment within the two years preceding renewal;
- Allows limited lines licensees from other states to receive a similar limited lines license in this State;
- Allows surplus lines brokers to be licensed as non-resident;
- Amends the statute to provide that all producers licensed in good standing in their home state will receive a non-resident license in this State upon application and upon payment of the application fee, without further documentation or other requirements; and

Uniformity

- Generally adopts the NAIC Model law;
- Eliminates separate licenses for brokers and agents ("Producers");
- Deletes the bond requirement for both residents and non-residents;
- Eliminates the separate license for fraternal agents;
- Adopts uniform standards for termination of appointments;
- Expands the definition of business entity to include professional associations and limited liability partnerships; and
- Allows for reciprocity in C.E. course/provider approval.

Effective date: July 2, 2001

Life and Health

SENATE BILL 132 (Chapter 26) - Health Insurance - Standard Provisions

- This bill strikes two standard contract provisions from the law:

§ 15-227 of the Insurance Article, which is the standard contract provision for noncoverage of a loss resulting from the insured's involvement in an illegal occupation.

§ 15-228 of the Insurance Article, which is the standard contract provision for noncoverage of a loss sustained or contracted as a result of the insured's being intoxicated or under the influence of any narcotic unless administered by a physician.

Effective date: January 1, 2002

SENATE BILL 457 (Chapter 388) - Health Insurance - Study of Maryland's Small Group Market

- Requires the Maryland Health Care Commission to:
 - (1) contract with an independent consultant to conduct a study comparing the performance of Maryland's small group health insurance market reform law to other states; and
 - (2) instruct the independent consultant to meet with and to provide periodic updates to an independent advisory committee comprised of small employers participating in the small group market, small employers who do not purchase group health insurance, insurers providing coverage in Maryland in the small group market, insurers not participating in the small group market in Maryland, HMOs, and agents and brokers in the small group market.
- In addition, SB 457 requires the study to include certain analysis and recommendations.
- Requires the Maryland Health Care Commission to report the findings and recommendations of the study to the Governor and the General Assembly on or before January 1, 2002.

Effective date: June 1, 2001. (This law shall be abrogated and of no further force and effect on January 1, 2002.)

SENATE BILL 458 (Chapter 389) - Health Insurance - Substantial, Available, and Affordable Coverage

- Defines health benefit plan under § 15-606.1(3) of the Insurance Article to specifically include certain coverages, as well as, exclude certain coverages and benefits.
- Defines SAAC under § 15-606.1(A)(4) of the Insurance Article to mean coverage that is offered in the nongroup health insurance market under the regulations adopted under § 15-606 of the Insurance Article.
- Applies to each carrier that offers a medically underwritten health benefit plan in the nongroup market in Maryland.
- Defines carrier to mean an insurer, nonprofit health benefit plan, or HMO.

- Requires a carrier that denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market to provide the individual with specific information regarding the availability of SAAC coverage in the form and manner required by the Commissioner (§ 15-606.1(C)(1) of the Insurance Article).
- Requires the Commissioner to:
- Adopt regulations to facilitate the implementation of § 15-606.1(C)(1) of the Insurance Article; and
- Develop a mechanism to provide verbally, in writing, or by electronic means, information to individuals, on request, about the availability of SAAC.
- Requires each carrier that offers a SAAC plan in the nongroup market to notify the Commissioner in writing, no later than January 1 of each year, of the time periods in that calendar year during which the carrier will offer its SAAC plan on an open enrollment basis.
- Section 2 of SB 458:
 1. Permits a carrier that offered a SAAC indemnity plan to any subscriber on January 1, 2001 to continue to provide that plan to existing subscribers of the plan;
 2. Provides that the plan is deemed in continued compliance with plan requirements under § 15-606 of the Insurance Article and the regulations adopted by the Health Services Cost Review Commission for SAAC plans; and
 3. Provides that this provision of SB 458 shall remain in effect for two years and, at the end of June 30, 2003, shall be abrogated and of no further force and effect.

Effective date: October 1, 2001

SENATE BILL 511 (Chapter 157) - Health Insurance - Requirements for Providers to Serve on Provider Panels - Dental Plans

Alters the definition of health benefit plan under § 15-112(e)(1) of the Insurance Article to include dental plans and other health benefit plans that contract with dentists to offer dental care services.

Effective date: October 1, 2001

SENATE BILL 522 (Chapter 736) - Health Insurance - Treatment of Morbid Obesity

- Defines "body mass index" and "morbid obesity".
- Applies to the following entities:

- (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State;
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; and
 - (3) managed care organizations, as defined in § 15-101 of the Health-General Article.
- Requires an entity to provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is:
 - (1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and
 - (2) consistent with criteria approved by the National Institutes of Health.
 - Requires an entity to provide the benefits required under this law to the same extent as for other medically necessary surgical procedures under the enrollee's or insured's contract or policy with the entity.

Effective date: October 1, 2001

SENATE BILL 591 (Chapter 406) - Health Insurance - Claims for Reimbursement for Health Care Services Rendered

- Clarifies § 15-1005(d)(1) of the Insurance Article that an insurer, nonprofit health service plan, or HMO must permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.
- Requires an insurer, nonprofit health service plan, or health maintenance organization that wholly or partially denies a claim for reimbursement to permit a provider a minimum of 90 working days after the date of denial of the claim to appeal the denial (§ 15-1005(d)(2) of the Insurance Article).
- Applies to claim denials made on or after October 1, 2001.

Effective date: October 1, 2001

SENATE BILL 686 (Chapter 416) - Health Insurance Benefit Cards, Prescription Benefit Cards, or Other Technology

- Applies to the following entities:
 - (1) insurers and nonprofit health service plans that provide coverage for prescription drugs on an outpatient basis under health insurance policies

- or contracts that are issued or delivered in the State;
- (2) health maintenance organizations that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State;
 - (3) managed care organizations, as defined in § 15-101 of the Health-General Article, that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State; and
 - (4) to the extent consistent with State and federal law, third party administrators.
- Exempts from the provisions of SB 686:
 - (1) short-term travel or accident-only policies;
 - (2) short-term nonrenewable policies of not more than six months' duration; or
 - (3) any health maintenance organization that operates or maintains its own pharmacies and dispenses, on an annual basis, over 90 percent of prescription drugs on an outpatient basis to its enrollees at its own pharmacies.
 - Requires an entity subject to the law to provide to its insureds, subscribers, or enrollees a health insurance benefit card, prescription benefit card, or other technology that:
 - (1) complies with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of issuance of the card or other technology; or
 - (2) includes, at a minimum, the following data elements:
 - (I) The name or identifying trademark of the entity subject to this section or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator;
 - (II) the name and identification number of the insured, subscriber, or enrollee;
 - (III) the telephone number that providers may call for pharmacy benefit assistance; and
 - (IV) all electronic transaction routing information and other numbers required by the entity subject to this section or benefit administrator to process a prescription claim electronically.
 - Requires an entity subject to the law that contracts with or otherwise arranges for the prescription benefit to be administered by another subsidiary or entity, including a pharmacy benefit manager, to require the benefit administrator to comply with the law.

- Requires the health insurance benefit card, prescription benefit card, or other technology to be issued to each insured, subscriber, or enrollee by an entity subject to the law.
- Requires an entity subject to the law, when there is a change in any of the data elements, to:
 - (1) reissue a health insurance benefit card, prescription drug benefit card, or other technology; or
 - (2) provide the insured, subscriber, or enrollee with the corrective information necessary to electronically process a prescription claim.
- Allows an entity subject to the law to comply with the law by issuing to each insured, subscriber, or enrollee a health insurance benefit card that contains data elements related to both prescription and nonprescription health insurance benefits.
- Requires DHMH to adopt regulations to enable managed care organizations to comply with:
 - (1) the law; and
 - (2) any unique requirements of the HealthChoice Program that relate to the electronic processing of claims.

Effective date: October 1, 2001

SENATE BILL 728 (Chapter 423) - Health Maintenance Organizations - Reimbursement of Noncontracting Providers for Services Rendered to Trauma Patients at Designated Trauma Centers

- Alters the definition of "covered service" under § 19-710(a)(3) of the Health-General Article to mean a health care service included in the benefit package of the health maintenance organization and rendered to an enrollee of the health maintenance organization by a health care provider, including a physician or hospital, not under written contract with the health maintenance organization.
- Alters the definition of "adjunct claims documentation" to mean an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland ambulance information systems form, or a medical record.
- Defines the following terms:
Under § 19-710.1(5) of the Health-General Article, "Institute" is the Maryland Institute for Emergency Medical Services System.

Under § 19-710.1(6) of the Health-General Article:

- (I) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the Institute to provide care to trauma patients.

- (II) "Trauma center" includes an out-of-state pediatric facility that has entered into an agreement with the Institute to provide care to trauma patients.

Under § 19-710.1(7) of the Health-General Article, "trauma patient" is a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

Under § 19-710.1(8) of the Health-General Article, "trauma physician" is a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

- Requires an HMO or its agent, for a covered service rendered to an enrollee of the HMO by a health care provider not under written contract with the HMO, to pay the claim submitted by a trauma physician for trauma care rendered to a trauma patient in a trauma center at the greater of:
 - (1) 140 percent of the rate paid by the Medicare Program, as published by HCFA for the same covered service to a similarly licensed provider; or
 - (2) the rate as of January 1, 2001 that the HMO paid in the same geographic area for the same covered service to a similarly licensed provider.
- § 19-710.1(b)(3) permits an HMO to require a trauma physician not under contract with the HMO to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the HMO.
- Requires an HMO that imposes the provisions of § 19.710.1(b)(3) on a trauma physician to assign a provider number to a trauma physician not under contract with the HMO, at the request of the physician.
- SB 728 shall remain effective until the termination provision in Chapter 275, Acts of 2000, takes effect.

Effective date: October 1, 2001

SENATE BILL 856 (Chapter 173) - Health Insurance - Appeals and Grievances Procedures - Modifications

- Requires a carrier under § 15-10A-02(b) of the Insurance Article to allow a member or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision for a retrospective denial.
- Alters § 15-10A-03(a)(1) to allow, within 30 working days after the date of receipt of a grievance decision, a member or a health care provider, who filed the grievance on behalf of the member under § 15-10A-02(b)(2) of the Insurance Article, to file a complaint with the Commissioner for review of the grievance decision.

- Requires each carrier subject to § 15-10A-06 of the Insurance Article to file with the Commissioner, on the form the Commissioner requires, a report that describes the number of adverse decisions issued by the carrier under § 15-10A-02(F) of the Insurance Article and the type of service at issue in the adverse decisions.
- Applies § 15-10A-03(a)(1) to all adverse decisions and grievance decisions made on or after October 1, 2001.
- Applies § 15-10A-06(a)(1)(vi) to adverse decisions made on or after January 1, 2002.

Effective date: October 1, 2001

HOUSE BILL 6 (Chapter 135) - Senior Prescription Drug Relief Act

Among other things, HB 6:

- Establishes the Maryland Pharmacy Discount Program under § 15-124.1 of the Health-General Article.
- Requires the Secretary of the Department of Health and Mental Hygiene (DHMH) to administer the Pharmacy Program as part of the Maryland Medical Assistance Program.
- Establishes the Maryland Medbank Program under § 15-124.2 of the Health-General Article.
- Alters the Short-Term Prescription Drug Subsidy Plan established under Title 15, Subtitle 6 of the Health-General Article.

Effective date: July 1, 2001 with certain exceptions. Also, Sections 9, 10, and 16 of the bill take effect on June 1, 2001.

HOUSE BILL 15 (Chapter 178) - Nonprofit Health Entity Accountability

Among other things, HB 15 sets forth the following:

- An exemption from taxation shall be granted to nonprofit health service plans under § 6-101(B)(1) of the Insurance Article so that funds which would otherwise have been collected by the State and spent for public purpose shall be used in a like manner and amount by the nonprofit health service plan.
- HB 15 does not apply to a nonprofit health service plan that insures less than 10,000 covered lives.
- Requires each nonprofit health service plan subject to the bill to file with the Commissioner a premium tax exemption report that:
 - (1) is in a form approved by the Commissioner, and
 - (2) demonstrates that the plan has used funds equal to the value of the

premium tax exemption provided to the plan under § 6-101(B) of the Insurance Article in a manner that serves the public interest in accordance with § 14-106(D) of the Insurance Article.

- Each report filed with the Commissioner is a public record.
- A nonprofit health service plan that fails to timely file the report required under § 14-106 of the Insurance Article shall pay the penalties under § 14-121 of the Insurance Article.
- By November 1 of each year, the Commissioner shall issue an order notifying each plan required to file a report under § 14-106 of the Insurance Article of whether the plan has satisfied the requirements of § 14-106 of the Insurance Article.
- A plan that does not meet the requirements of § 14-106 of the Insurance Article shall have one year from the date the Commissioner issued the Order to comply with the requirements of § 14-106 of the Insurance Article.
- A party aggrieved by an Order of the Commissioner issued under § 14-106 of the Insurance Article has a right to a hearing in accordance with §§ 2-210 through 2-215 of the Insurance Article.
- If after one year from the Order the Commissioner determines that a plan has not satisfied the requirements of § 14-106 of the Insurance Article, the Commissioner shall report the determination to the House Economic Matters Committee and the Senate Finance Committee.
- Only by an Act of the General Assembly can a nonprofit health service plan be subject to the premium tax under Title 6, Subtitle 1 of the Insurance Article.

Effective date: October 1, 2001

HOUSE BILL 25 (Chapter 179) - Life Insurance - Insurable Interest in Adopted Child

- Clarifies that for a prospective parent of a prospective adoptive child, an insurable interest exists in the life of the child as of the date of the earlier of:
 - (1) A placement for adoption, as defined in § 5-301 of the Family Law Article, provided that:
 - A. any consents required under § 5-311 of the Family Law Article have been given; or
 - B. a decree awarding guardianship has been granted under § 5-317 of the Family Law Article; or
 2. An interlocutory or final degree of adoption.

Effective date: October 1, 2001

HOUSE BILL 160 (Chapter 445) - Health Insurance - Hearing Aids - Coverage for Children

- Applies to:
 - (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and
 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.
- Requires an entity subject to § 15-837 of the Insurance Article to provide coverage for hearing aids for a minor child who is covered under a policy or contract if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.
- An entity subject to § 15-837 of the Insurance Article may limit the benefit payable under § 15-837(c)(1) to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.
- Applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2001.

Effective date: October 1, 2001

HOUSE BILL 179 (Chapter 53) - Health Insurance - Private Review Agents and Complaint Process

- Clarifies that §§ 15-10B and 10D of the Insurance Article apply to HMOs.
- Clarifies that an HMO may not fail to comply with the provisions of § 15-10D of the Insurance Article.
- Clarifies that under certain circumstances a private review agent's grievance decision shall be made based on the professional judgment of:
 - (1) A physician who is board certified or eligible in the same specialty as the treatment under review; or
 - (2) A panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or eligible in the same specialty under review.
 - (3) When the grievance decision involves a mental health or substance service:

- (I) A licensed physician who:
 1. Is board certified or eligible in the same specialty as the treatment under review; or
 2. Is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review; or

- (II) A panel of other appropriate health care service reviewers with at least one physician, selected by the private review agent who:
 1. Is board certified or eligible in the same specialty as the treatment under review; or

 2. Is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

Effective date: January 1, 2002

HOUSE BILL 190 (Chapter 128) - Health Insurance - Colorectal Cancer Screening - Coverage

- Applies to the following entities:
 - (1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

 - (2) HMOs that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

- An entity subject to HB 190 shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

- The coverage required under HB 190 may be subject to a copayment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.

- Applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after July 1, 2001.

Effective date: July 1, 2001

HOUSE BILL 1042 (Chapter 701) - Health Insurance - Acquisition of Nonprofit Entity

- Amends § 6.5-303 of the State Government Article to repeal a provision that requires the Commissioner to consider whether the acquisition is approved by

at least two-thirds of the transferor's certificate holders who have voted on the acquisition for the purpose of determining whether to approve the acquisition of a nonprofit health service plan.

- Establishes that, if the Maryland Health Care Foundation receives a distribution of public or charitable assets as the result of an acquisition of a nonprofit health service plan or a nonprofit health maintenance organization, approved by the Maryland Insurance Administration on or after June 1, 2001, that:
 - A.
 - (1) There is a Maryland Health Care Trust;
 - (2) The Trust is a body corporate, subject to modification or termination by the General Assembly;
 - (3) The purpose of the Trust is to:
 - (i) be of general benefit to the residents of the State;
 - (ii) be charitable in nature; and
 - (iii) to accept and retain moneys for future expenditures to be used to implement Acts of the General Assembly, other than the State budget bill, that:
 - 1. improve the health status of residents of the State; and
 - 2. specifically direct the use of assets of the Trust; and
 - (4) Moneys expended from the Trust are supplemental to, and are not intended to take the place of, State funds that would otherwise be appropriated by the State for the improvement of the health care status of the residents of the State;
 - B.
 - (1) The Maryland Health Care Foundation shall be the Trustee of the Trust; and
 - (2) The powers and duties of the Trust shall rest in and be exercised by the Trustee;
 - C. The powers and duties of the Trust shall be established and modified solely by the General Assembly;
 - D. The Trust consists of the public and charitable assets received by the Maryland Health Care Foundation as a result of the acquisition of a nonprofit health service plan or a nonprofit health maintenance organization, approved by the Maryland Insurance Administration on or after June 1, 2001, in accordance with Title 6.5 of the State Government Article.
 - E. The State Treasurer shall manage, invest, and reinvest the Trust in the same manner as State funds are invested, provided, however, that the Trust shall be held and accounted for separate and apart from the funds of the State;
 - F.
 - (1) Subject to item (2) of this subsection, any interest or other investment earnings of the Trust shall be credited and paid into the Trust; and
 - (2) The Trustee shall grant to the Maryland Health Care Foundation any interest and other investment earnings that accrue on the assets of the Trust before July 1, 2002, not exceeding a total of

\$10,000,000; and

- G. (1) The Trustee shall make provision for a system of financial accounting, controls, audits, and reports; and
- (2) The Trustee shall report to the Governor, and, in accordance with § 2-1246 of the State Government Article, to the General Assembly on or before December 1, 2001 and annually thereafter on the status of the assets of the Trust.

Effective date: October 1, 2001

HOUSE BILL 1396 (Chapter 329) - Long-Term Care Insurance - Loss Ratios - Premium Increases

- Repeals § 18-115(a) of the Insurance Article which requires benefits under a policy or certificate of long-term care insurance to be considered reasonable in relation to premiums if the expected loss ratio is at least 60 percent and is calculated in a manner that provides for adequate reserving of the long-term care insurance risk.
- Allows for the Maryland Insurance Administration to adopt the NAIC model regulations regarding rate stabilization which permits a lower loss ratio for new contracts.

Effective date: October 1, 2001

HOUSE BILL 1448 (Chapter 563) - Medicare Supplement Policies - Medicare Select Program

- Authorizes an insurer or a nonprofit health service plan that is authorized to issue Medicare Supplement policies under the Insurance Article to issue Medicare Supplement policies under the Medicare Select Program (§ 15-904 of the Insurance Article).
- Establishes that the requirements for a Medicare Supplement policy issued under the Medicare Select Program shall be consistent with the requirements set forth in the Federal Omnibus Budget Reconciliation Act of 1990 and any subsequent relevant federal law and regulations.
- Requires DHMH to determine the adequacy of the network established by an insurer or a nonprofit health service plan under the Medicare Select Program, as to the number of providers, geographic location, hours of operation, promptness of service, and range of services, in the same manner as determined for a health maintenance organization under §§ 19-705.1 and 19-705.2 of the Health-General Article.
- Allows the Commissioner to adopt regulations, in consultation with DHMH, to establish the requirements of the Medicare Select Program.

Effective date: October 1, 2001

Property and Casualty

SENATE BILL 509 (Chapter 392) - Property and Casualty Insurance - Limitation of Reduction Due to Workers' Compensation Benefits

- Establishes that the benefits payable under the coverages described in §§ 19-505 and 19-509 of the Insurance Article shall be reduced to the extent the recipient has recovered benefits under the workers' compensation laws of a state or the federal government for which the provider of the workers' compensation benefits has not been reimbursed (§ 19-513(e) of the Insurance Article).

Effective date: October 1, 2001

SENATE BILL 797 (Chapter 625) - Property and Casualty Insurers - Geographic Distribution of Private Passenger and Residential Property Premium

- Alters the definition of "major insurer" to mean an insurer or affiliate or subsidiary of that insurer that has written an amount of private passenger premium in the State that totals one percent or more of the total premium of private passenger premium written in the State by all insurers, including the Maryland Automobile Insurance Fund.

Effective date: June 1, 2001

HOUSE BILL 148 (Chapter 443) - Boiler and Pressure Vessel Safety - Regulation of Inspectors, Owners, Repair Companies and Insurance Companies

- Among other things, under § 176C of Article 48 - Inspections, an authorized insurer that provides coverage for boiler or pressure vessels is required to conduct the certificate inspection for each covered boiler and pressure vessel that the company insures by the date the inspection is due.
- Enforcement of HB 148 is with the Commissioner of Labor and Industry.

Effective date: June 1, 2001

HOUSE BILL 180 (Chapter 447) - Homeowner's Insurance and Private Passenger Motor Vehicle Insurance - Standards for Cancellation and Nonrenewal - Repeal of Sunset

- Repeals the sunset provision that would have repealed Chapter 652 of the Acts of 1998.

Effective date: June 1, 2001

HOUSE BILL 265 (Chapter 209) - Title Insurers - Statements of Financial Condition - Exemption from Filing Requirement

- Exempts law firms and individual attorneys practicing in law firms from the requirement under § 10-121(J) of the Insurance Article.

Effective date: October 1, 2001

HOUSE BILL 385 (Chapter 218) - Insurance - Improper Premiums and Charges - Policy Fee Charged by Surplus Lines Brokers

- Establishes different fee limits that can be charged by a surplus lines broker under § 27-216 of the Insurance Article for a personal lines policy and a commercial lines policy.
- Under certain circumstances, a surplus lines broker may charge a reasonable policy fee not exceeding:
 - (I) \$100 on each personal lines policy procured by a qualified agent or qualified broker to whom the surplus lines broker pays a commission;
or
 - (II) \$250 on each commercial lines policy procured by a qualified agent or qualified broker to whom the surplus lines broker pays a commission.

Effective date: October 1, 2001

HOUSE BILL 387 (Chapter 219) - Insurance - Premium Financing

- Requires an agent, broker, or premium finance company to send a copy of the premium finance agreement or other notice of premium to the surplus lines broker when a policy is procured through a surplus lines broker in the State and payment is not made directly to the surplus lines broker or the insurer.
- Permits a premium finance company to require an agent or broker who procures premium financing to:
 - (I) send to the surplus lines broker the notice required under § 23-302(B)(1) of the Insurance Article within 10 business days of the execution of the premium finance agreement; and
 - (II) provide to the premium finance company, within 10 business days of receipt of a policy, the insured's name, policy number, and any other information necessary to complete a premium finance agreement.

- Requires an agent or broker to return any gross unearned commissions, calculated as provided in subsection § 23-405(A)(1) of the Insurance Article, to an insurer within a reasonable period of time as required by the insurer.

Effective date: October 1, 2001

HOUSE BILL 1388 (Chapter 327) - Vehicle Laws - Insurance Claim Settlements - Salvage

Among other things, Chapter 327:

- Provides that when possession of a vehicle that is salvage is retained by the owner of the vehicle at the conclusion of a claim settlement by an insurance company, the insurance company is not considered to have acquired the vehicle (§ 11-152 of the Transportation Article).
- Alters the requirements for an insurance company to notify the Motor Vehicle Administration when the company makes a claim settlement on a vehicle that is salvage and retained by the owner under § 13-506 of the Transportation Article.
- Alters certain notice requirements for insurers under § 13-506 of the Transportation Article.
 - *Effective date: July 1, 2001*

Miscellaneous

SENATE BILL 592 (Chapter 609) - Workers' Compensation Insurers and Self-Insurers - Office and Personnel Requirements

- Among other things, the law sets forth the following provisions:

Under § 9-405 of the Labor and Employment Article, each employer that self-insures under this law is required to have in the State competent individuals who:

- (I) handle and adjust each disputed workers' compensation claim in the State for the employer; and
- (II) possess the knowledge and experience to handle and adjust each disputed claim.

Under § 9-410 of the Labor and Employment Article, an insurer that provides workers' compensation insurance in the State is required to have in the State competent individuals who:

- (I) handle and adjust each disputed workers' compensation claim in the State for the employer; and

(II) possess the knowledge and experience to handle and adjust each disputed claim.

Effective date: October 1, 2001

SENATE BILL 763 (Chapter 426) - Workers' Compensation - Self-Insurance Groups

- Defines "insolvent self-insurance group" under § 25-301 of the Insurance Article to mean a self-insurance group in which each individual member of the group is unable to meet the member's debts as they mature in the ordinary course of business as determined by the Commissioner.
- Clarifies under § 25-304 of the Insurance Article that a self-insurance group shall pay all workers' compensation benefits for which each member incurs liability during its period of membership.
- Clarifies under § 25-304 of the Insurance Article that each member of a self-insurance group is jointly and severally liable for the workers' compensation obligations of the group and its members that are incurred during its period membership.
- Clarifies under § 25-304 of the Insurance Article that a member who elects to terminate its membership in or is canceled by a group remains jointly and severally liable for workers' compensation obligations of the group and its members which were incurred during the canceled or terminated member's period of membership.
- Requires the Maryland Insurance Administration to report to the Senate Finance Committee and the House Economic Matters Committee, on or before December 1, 2001, on the following:
 - (1) the name of each workers' compensation self-insurance group, the type of businesses that generally become members of each group, the number of employers that belong to each group, and the total number of employees that are served by each group;
 - (2) the status of the regulation and operation of the workers' compensation self-insurance groups; and
 - (3) any recommendations for changes to the law regarding the regulation of workers' compensation self-insurance groups.

Effective date: October 1, 2001

SENATE BILL 837 (Chapter 434) - Insurance - Insurance Insolvencies - Claims Priority

- Alters the priority of distribution in the event of an insurer insolvency when there are known or potential claims due the federal government.
- Prioritizes claims of guaranty corporations before claims of the federal government.

Effective date: October 1, 2001

SENATE BILL 865 (Chapter 174) - Dental Plan Organizations - Solvency Requirements

- Alters the circumstances under which a dental plan organization is exempted from § 14-404 of the Insurance Article to include the following provision:
 - (I) did not have any enrollees as of January 1, 2000;
- Provides that a dental plan organization does not qualify for exemption from the provisions of § 14-404 of the Insurance Article if the dental plan organization has one or more enrollees on or after January 1, 2000.

Effective date: October 1, 2001

HOUSE BILL 153 (Chapter 51) - Insurance - Risk Based Capital Standards for Insurers - Exemption

- Authorizes the Commissioner to exempt certain health insurers from the application of the risk based capital standards set forth in Title 4 of the Insurance Article.

Effective date: July 1, 2001

HOUSE BILL 283 (Chapter 652) - Insurance - Late Fees and Installment Fees

- Under certain circumstances, HB 283 allows an authorized insurer to charge and collect, if approved by the Insurance Commissioner, reasonable installment fees or late fees for late payment of premiums by policyholders or both.
- Requires the Insurance Commissioner to review administrative expenses submitted by an authorized insurer that are associated with late payments or installment payments.
- Authorizes the Insurance Commissioner to approve a late fee or installment fee of not more than \$10.
- Prohibits the imposition of a late fee:
 1. During any grace period required by law or regulation on a policy of insurance; or

2. If no grace period is required by law or regulation on a policy of insurance, until two business days after the date the payment amount becomes due.

- Requires an authorized insurer to credit each payment received from an insured to the premium owed by the insured before crediting the payment to a late fee or installment fee owed by the insured.
- Prohibits the cancellation of a policy of insurance for the failure to pay a single late fee or installment fee.

Effective date: October 1, 2001

HOUSE BILL 362 (Chapter 469) - Maryland Insurance Administration - Adoption of Regulations

- Requires the Insurance Commissioner to promulgate regulations that establish standards governing the privacy of consumer financial and health information pursuant to Title V of the Federal Financial Services Modernization Act of 1999.
- Requires the regulations promulgated in accordance with § 2-109(D)(1) to be consistent with the provisions of the model regulation adopted by the National Association of Insurance Commissioners entitled, "Privacy of Consumer Financial and Health Information Regulation".
 - The regulations adopted in accordance with § 2-109(d) of the Insurance Article may not take effect before January 1, 2002.
- Requires the Insurance Commissioner to establish criteria and a process to allow an individual who is otherwise prohibited from engaging in or participating in the business of insurance under the Federal Violent Crime Control and Law Enforcement Act of 1994 to obtain written consent from the Commissioner to engage in or participate in the business of insurance under the Federal Act.

Effective date: July 1, 2001

HOUSE BILL 937 (Chapter 285) - Financial Guaranty Insurance Companies - Definition and Home Office Requirement

- Alters the definition of a "financial guaranty insurance company" to allow certain financial guaranty insurance companies to have a home or executive office outside the State under certain circumstances.

Effective date: July 1, 2001

HOUSE BILL 1412 (Chapter 332) - Insurance - Assets, Reserves, and Investments of Insurers

- Alters the assets owned by an insurer that are required to be allowed as admitted assets under § 5-101(a) of the Insurance Article.
- For the purpose of determining the financial condition of an insurer, alters the items related to investments, securities, properties, or loans that the insurer owns that are required to be allowed as admitted assets under § 5-101(b) of the Insurance Article.
- Alters the assets that are not allowed as admitted assets under § 5-102(a) of the Insurance Article.
- Repeals § 5-204 of the Insurance Article, which governs loss reserves for certain liability and workers' compensation insurance.
- Alters the manner in which reserves are computed under § 5-205 of the Insurance Article.
- Alters the reserve requirements for a title insurer under § 5-206 of the Insurance Article.
- Alters from 15 percent to ten percent or more under which an insurer that owns stock of another insurer must have its stock valued at book value under § 5-401(b) of the Insurance Article.
- Alters § 5-401(d) of the Insurance Article as to the valuation of real estate investments of insurers.
- Alters § 5-508 of the Insurance Article to allow a life insurer to lend to its policyholder on the policy as collateral security an amount not exceeding the cash surrender value of the policy.

Effective date: October 1, 2001

INSURANCE REGULATIONS

July 1, 1999 – June 30, 2001

Life and Health

Chapter Affected: COMAR 31.05.06 Valuation of Life Insurance Policies (“Triple X”)

This action amended the MIA’s regulations on the valuation of life insurance policies to bring them into conformity with the NAIC Valuation of Life Insurance Policies Model Regulation, which the NAIC adopted in March 1999. The action clarified the appropriate reserve methodology for term products and updated the tables of select mortality factors to better reflect current experience.

Effective Date, Permanent Adoption:

May 15, 2000

Chapter Affected: COMAR 31.10.06 Standards for Medicare Supplement Policies

This action prohibits insurance companies and nonprofit health service plans from raising premium rates for a Medicare Supplement plan: (1) for at least one year after the original issuance of a policy or certificate; and (2) more than once a year thereafter.

Effective Date, Emergency Status:

January 1, 2000

Effective Date, Permanent Adoption:

August 21, 2000

Chapter Affected: COMAR 31.10.06 Standards for Medicare Supplement Policies

This action brought the Medicare Supplement regulations into compliance with the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. The changes were required by the Balanced Budget Refinement Act of 1999 (BBRA), the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), and the Balanced Budget Act of 1997. If the regulations had not been amended, Maryland would have been out of compliance with federal standards and would have lost the right to regulate Medicare Supplement insurance.

Effective Date, Emergency Status:

July 25, 2000

Effective Date, Permanent Adoption:

November 13, 2000

Chapter Affected: COMAR 31.10.11 Uniform Claim Forms (“Clean Claims”)

This action implements §15-1003(d) of the Insurance Article, which requires the Insurance Commissioner to adopt regulations that:

- define a clean claim;
- establish permissible categories of disputed claims for which additional information may be requested; and
- establish standards for determining when a claim is received for reimbursement.

Effective Date, Permanent Adoption:

September 7, 2001

Chapter Affected: COMAR 31.10.15 Substantial, Available, and Affordable Coverage Plan

This action adopted changes to the Substantial, Available, and Affordable Coverage (SAAC) health benefit plan that conform to changes made to the Comprehensive Standard Health Benefit Plan (CSHBP) as a result of the last two annual reviews of CSHBP. The changes include additional benefits, changes in cost-sharing requirements, and the institution of an open prescription drug formulary.

Effective Date, Emergency Status:

August 7, 2000

Effective Date, Permanent Adoption:

November 27, 2000

Chapter Affected: COMAR 31.10.15 Substantial, Available, and Affordable Coverage Plan

This action:

- added, excluded, and limited certain benefits under the Substantial, Available, and Affordable Coverage (SAAC) Plan;
- increased the amount of deductibles and copayments under the SAAC Plan; and
- clarified that the changes to the SAAC Plan made as a result of the Health Care Commission's annual review are effective for contracts issued or renewed after July 1 of the calendar year in which the changes are promulgated.

Effective Date, Permanent Adoption

April 16, 2001

Chapter Affected: COMAR 31.10.21 Private Review Agents

This action established a uniform treatment plan form for use when a private review agent requires a health care provider to submit a treatment plan to enable the private review agent to conduct utilization review of services for the treatment of a mental illness, emotional disorder, or a drug or alcohol abuse disorder.

Effective Date, Permanent Adoption:

August 21, 2000

Chapter Affected: COMAR 31.10.22 Provider-Sponsored Organizations

This action established procedures and requirements for the certification of provider-sponsored organizations in accordance with Title 19, Subtitle 7A of the Health-General Article.

Effective Date, Emergency Status:

June 29, 1999

Effective Date, Permanent Adoption:

May 15, 2000

Chapter Affected: COMAR 31.10.23 Penalties for Failure to Make Prompt Payment of Claims.

This action clarified the penalties to which a health insurer, nonprofit health service plan, and health maintenance organization are subject for failure to comply with the statutory provisions on prompt payment of claims.

Effective Date, Emergency Status:

April 12, 1999

Effective Date, Permanent Adoption:

December 13, 1999

Chapter Affected: COMAR 31.10.25 Required Standard Provisions for Individual Nonprofit Health Service Plan Contracts

This action implements §12-203(g) of the Insurance Article, which requires the Commissioner to adopt regulations that establish the language and format for standard provisions required for individual nonprofit health service plan contracts.

Effective Date, Permanent Adoption:

October 30, 2000

Chapter Affected: COMAR 31.10.26 Uniform Credentialing Form

This action implements the provision of Chapter 589, Acts of 1999, relating to a uniform credentialing form. The regulations require carriers and credentialing intermediaries to accept a certain form for credentialing and recredentialing healthcare providers for participation on a provider panel. The regulations also require carriers and credentialing intermediaries to make the form available to providers.

Effective Date, Permanent Adoption:

December 25, 2000

Chapter Affected: COMAR 31.11.06 Comprehensive Standard Health Benefit Plan

This action:

- added certain benefits to the Comprehensive Standard Health Benefit Plan (CSHBP), including annual chlamydia screening;
- implemented use of a three-tier open formulary for prescription drugs under the CSHBP; and
- increased the amount of deductibles and copayments under the CSHBP.

Effective Date, Permanent Adoption:

February 7, 2000

Chapter Affected: COMAR 31.11.06 Comprehensive Standard Health Benefit Plan

This action:

- added certain benefits to the Comprehensive Standard Health Benefit Plan (CSHBP), including colorectal screening;
- increased the amount of deductibles and copayments under the CSHBP; and
- made certain clarifying changes to the CSHBP, including clarifying that dental implants are excluded from coverage, that coverage of medical foods is limited to individuals with metabolic disorders, and that the copayment for maintenance drugs is applicable to a 90-day supply of maintenance drugs.

Effective Date, Permanent Adoption:

February 5, 2001

Chapter Affected: COMAR 31.11.10 Required Standard Provisions for Group Contracts

This action implements §12-203(g) of the Insurance Article, which requires the Commissioner to adopt regulations that establish the language and format for standard provisions required for contracts and policies issued by insurers and nonprofit health service plans.

Effective Date, Permanent Adoption:

October 30, 2000

Chapter Affected: COMAR 31.12.02 Health Maintenance Organizations – Contract Forms and Premium Rates

The regulations previously required each individual and group contract to provide that an HMO shall notify a contract holder of any increase in charges at least 40 days before the change

is proposed to become effective. This action amended the regulations to require the notice be given at least 45 days before the change is proposed to become effective. This change made the regulations consistent with the notice requirements of §15-122(b) of the Insurance Article, as amended by Chapter 537, Acts of 1998.

Effective Date, Permanent Adoption:

January 9, 2000

Chapter Affected: COMAR 31.12.07 Required Standard Provisions for HMO Contracts

The purpose of this action is to implement §12-203(g) of the Insurance Article, which requires the Commissioner to adopt regulations that establish the language and format for standard provisions required for contracts and policies issued by health maintenance organizations.

Effective Date, Permanent Adoption:

October 30, 2000

Chapter Affected: COMAR 31.13.01 Standards for Credit Life and Credit Health Insurance

This action requires insurers to report to the Commissioner certain information regarding accounts that qualify as cases. It also requires an insurer that begins to offer credit insurance through a case to use appropriate premium rates and file appropriate experience reports.

Effective Date, Permanent Adoption:

May 15, 2000

Chapter Affected: COMAR 31.13.01 Standards for Credit Life and Credit Health Insurance

This action reduced the prima facie premium rates for credit life and credit health insurance to levels anticipated to produce prima facie loss ratios that satisfy regulatory requirements.

Effective Date, Permanent Adoption:

March 1, 2001

Chapter Affected: COMAR 31.13.01 Standards for Credit Life and Credit Health Insurance

This action made extensive changes to the credit life and credit health insurance regulations in order to clarify and update the regulations.

Effective Date, Permanent Adoption:

March 1, 2001

***Property and
Casualty***

Chapter Affected: COMAR 31.03.06 Surplus Lines

This action identifies coverages that are eligible for placement with a surplus lines insurer without first conducting a diligent search.

Effective Date, Emergency Status:

June 29, 1999

Effective Date, Permanent Adoption:

May 1, 2000

Chapter Affected: COMAR 31.03.06 Surplus Lines

This action requires the written disclosure that accompanies a surplus lines insurance policy under §3-308 of the Insurance Article to be:

- in a particular form;
- provided to the insured at the time of the initial purchase of insurance from a surplus lines insurer and at each renewal of the insurance;
- with respect to insurance covering residential property, signed by the insured and retained by the surplus lines broker for at least three years; and
- with respect to insurance not covering residential property, provided to the insured in a certain manner and retained by the surplus lines broker for at least three years.

Effective Date, Permanent Adoption:

June 11, 2001

Chapter Affected: COMAR 31.07.02 Filing of Rate Level Index Information

This action expanded the amount of information regarding premiums for auto insurance that insurers are required to provide to the MIA. The MIA will use the additional information to expand and improve its Automobile Rate Guide.

Effective Date, Permanent Adoption:

November 13, 2000

Chapter Affected: COMAR 31.15.10 Homeowner’s Insurance and Private Passenger Motor Vehicle Insurance – Standards for Cancellation and Nonrenewal

This action implements the provisions of Chapters 651 and 652, Acts of 1998, which modified the “Crumlish” standard. The regulations clarify the standards for cancellation or nonrenewal of homeowner’s insurance based on weather-related claims; clarify the standards for cancellation or nonrenewal of private passenger motor vehicle insurance based on claims or possible criminal conduct; and prohibit an insurer from canceling or nonrenewing a risk if the insurer has a filed rate that is applicable to that risk.

Effective Date, Emergency Status:

February 4, 1999

Effective Date, Permanent Adoption:

March 6, 2000

Chapter Affected: COMAR 31.15.11 Use of Credit Information in Underwriting and Rate Making

This action requires insurers that use credit reports or credit scores for underwriting or rate-making purposes, with respect to personal lines of property and casualty insurance, to provide the Commissioner with the underlying information that the Commissioner needs to ensure that the insurers use the credit reports or credit scores in accordance with the standards for underwriting and rate making that currently exist in Maryland law. This action also requires insurers that use credit reports or credit scores for certain adverse actions, with respect to personal lines of property and casualty insurance, to notify consumers of the actual reason for the adverse action in accordance with current Maryland law.

Effective Date, Permanent Adoption:

May 15, 2000

Hearings

Chapter Affected: COMAR 31.02.02 Hearings Conducted by Administrative Law Judges

This action clarifies that, if the Commissioner issues a final order that summarily affirms the proposed decision of an administrative law judge, neither the final order nor the proposed decision is precedent or persuasive authority.

Effective Date, Emergency Status:

September 14, 1999

Effective Date, Permanent Adoption:

April 3, 2000

Miscellaneous

Chapter Affected: COMAR 31.16.07 Holocaust Victims Insurance Claims and Reports

This action established procedures and standards for:

- the diligent and expeditious investigation of insurance claims of Holocaust victims by insurers;
- the use of alternative documentation to substantiate the insurance claims of Holocaust victims;
- computing interest on the face or other pay-out value of an insurance policy or annuity issued to a Holocaust victim; and
- filing reports that the Commissioner may direct an insurer to file relating to insurance claims of Holocaust victims.

Effective Date, Permanent Adoption:

June 25, 2001

INSURANCE BULLETINS

July 1, 1999 – June 30, 2001

All bulletins are available on the Maryland Insurance Administration website, www.mdinsurance.state.md.us. Bulletins are listed under Available Public Information.

1999

Unnumbered Joint Bulletin of the MIA and the Health Services Cost Review Commission

Issued To: All Payers

Re: Health Services Cost Review Commission's Alternative Payment Methodology

Date of Issuance: July 23, 1999

Bulletin No.: 99-16

Issued To: Compliance Officers for Carriers Using Provider Panels

Re: Required Filings of Procedures for Specialist Referrals

Date of Issuance: August 4, 1999

Bulletin No. 99-17

Issued To: Small Group Health Maintenance Organizations

Re: Contract Filings

Date of Issuance: August 17, 1999

Bulletin No.: 99-18

Issued To: Small Group Carriers

Re: Contract Filings

Date of Issuance: September 17, 1999

Bulletin No.: 99-19

Issued To: Payers and Hospitals Participating in the HSCRC Current Financing Program

Re: Application of the Prompt Payment Statute When a Payer Advances Working Capital to a Hospital

Date of Issuance: September 24, 1999

Bulletin No.: 99-20

Issued To: Health Insurers, Health Maintenance Organizations, and Private Review Agents

Re: Group Contracts: Retroactive Termination and Adverse Decisions

Date of Issuance: November 19, 1999

Bulletin No.: 99-21

Issued To: President, All Domestic Insurance Companies, HMOs, Non-Profits, Dental Plans, MCOs, etc.

Re: Post Year 2000 Reporting Requirements and Data Archiving

Date of Issuance: December 1, 1999

Bulletin No.: 99-22

Issued To: Property and Casualty Insurance Companies, Title Insurance Companies, and Rating Organizations

Re: Revised Rate and Form Filing Procedure

Date of Issuance: December 2, 1999

Bulletin No.: 99-23

Issued To: Medicare Supplement Insurers

Re: Revision to Regulations – Limitation on Implementing Rate Increases

Date of Issuance: December 10, 1999

Bulletin No.: 99-24

Issued To: All Health Insurance Carriers

Re: Medical Clinical Trials Reporting

Date of Issuance: December 22, 1999

Bulletin No.: 99-25

Issued To: All Health Insurance Carriers

Re: Denial of Ancillary Charges

Date of Issuance: December 22, 1999

2000

Bulletin No.: 00-1

Issued To: Small Group Carriers

Re: Offer of Standard Plan and Additional Benefits

Date of Issuance: January 7, 2000

Bulletin No.: 00-2

Issued To: President, Managed Care Organizations

Re: Risk-Based Capital Reporting Requirements

Bulletin No.: 00-3

Issued To: Medicare Supplement Insurers

Re: Revision to Regulations – Limitation on Implementing Rate Increases

Date of Issuance: February 15, 2000

Bulletin No.: 00-4

Issued To: Health Maintenance Organizations

Re: Rescission of MIA Position As Stated in Wickenden Letter: Methodology for Payment of Usual, Customary, and Reasonable Rates to Noncontracting Providers

Date of Issuance: February 23, 2000

Bulletin No.: 00-5

Issued To: All Motor Vehicle Liability Insurers

Re: Personal Injury Protection Coverage

Date of Issuance: April 25, 2000

Bulletin No.: 00-6

Issued To: Rate and Form Filing Department of Property and Casualty Insurance Companies, Title Insurance Companies, and Rating Organizations

Re: Revised Procedures for the Calculation of Filing Fees for Form Filings

Date of Issuance: February 25, 2000

Bulletin No.: 00-7

Issued To: Life and Health Insurers

Re: Life, Accident and Health Insurers Required Filings Checklist

Date of Issuance: March 1, 2000

Bulletin No.: 00-8

Issued To: Small Group Insurance Companies

Re: Contract Filings

Date of Issuance: March 8, 2000

Bulletin No.: 00-9

Issued To: Small Group Health Maintenance Organizations

Re: Contract Filings

Date of Issuance: March 8, 2000

Bulletin No.: 00-10

Issued To: All Insurers

Re: Estimated Premium Tax Filings

Date of Issuance: March 29, 2000

Bulletin No.: 00-11

Issued To: Private Review Agents, Health Maintenance Organizations, Nonprofit Health Service Plans, and Health Insurers

Re: Utilization Review Criteria and Standards – Disclosure to Providers

Date of Issuance: May 2, 2000

Bulletin No.: 00-12

Issued To: Small Group Carriers

Re: Revised Definition of Small Employer

Date of Issuance: May 2, 2000

Bulletin No.: 00-13

Issued To: Health Maintenance Organization, Managed Care Organizations, Persons Who Enter Into Administrative Service Provider Contracts Under §19-713.2 of the Health General Article

Regulation of Down Stream Risk

Date of Issuance: June 7, 2000

Bulletin No.: 00-13

Re: Revised Maryland Insurance Administration Contracting Provider Application

Date of Issuance: June 12, 2000

Bulletin No.: 00-14

Issued To: Small Group Carriers

Re: Reduction of Benefits for Medicare Eligible Employees

Date of Issuance: June 14, 2000

Revised Bulletin No.: 00-12

Issued To: Small Group Carriers

Re: Small Employer Groups: Revised Rules for Eligibility and Group Size

Date of Issuance: June 14, 2000

Bulletin No.: 00-15

Re: Maintaining group health insurance benefits after leaving group

Date of Issuance: June 23, 2000

Attachment to Life & Health 00-15

Continuation of Benefits Comparison of Maryland and Federal Provisions

Date of Issuance: June 23, 2000

Uniform Treatment Plan Form

Date of Issuance: August 15, 2000

Bulletin No.: 19

Issued To: Private Review Agents, Health Maintenance Organizations, Non-Profit Health Service Plans, Health Insurers

Re: Uniform Treatment Plan Form Regulations

Date of Issuance: September 20, 2000

Bulletin No.: 22

Issued To: All Licensed Insurers, Health Maintenance Organizations and Other Interested Parties in Maryland

Re: Enforcement of Gramm-Leach-Bliley Privacy Regulations

Date of Issuance: November 17, 2000

Bulletin No.: 25

Issued To: Credit Insurance Companies

Re: Revisions to COMAR 31.13.01 – Standards for Credit Life and Credit Health Insurance

Date of Issuance: December 12, 2000

Bulletin No.: 26

Issued To: Health Maintenance Organizations and Healthchoice Managed Care Organizations

Re: Implementation of Chapter 323, Acts of the General Assembly of 2000 Downstream Risk Regulation

Date of Issuance: December 22, 2000.

2001

Bulletin No.: 01-05

Issued To: Insurance Companies with Approved Individual Long-Term Care Contracts

Re: Revised Interpretation of Regulation

Date of Issuance: February 16, 2001

Bulletin No.: 01-07

Issued To: Small Group Health Maintenance Organizations

Re: Contract Filings

Date of Issuance: March 7, 2001