Unofficial Copy 1997 Regular Session
C4 7lr1018

By: The Speaker (Department of Legislative Reference - Code Revision)
Introduced and read first time: January 23, 1997
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Insurance Article - Code Revision - Supplemental Provisions

FOR the purpose of adding certain provisions to the Insurance Article, to revise, restate, and recodify the laws of the State relating to: certain duties of the Insurance Commissioner as to private passenger automobile insurance, disclosure requirements for insurers as to certain claims and actions, medical files, and medical information, retaliation for certain taxes and other obligations, certain simplified policies of insurance, certain policies of motor vehicle insurance, and certain duties of the Maryland Automobile Insurance Fund; revising and transferring to the Session Laws certain provisions relating to: the Maryland Standard Nonforfeiture Law for Life Insurance, the Maryland Standard Nonforfeiture Law for Individual Deferred Annuities, investments of life insurers, agent appointments, limited benefits policies of health insurance, insurer insolvencies, the Medical Mutual Liability Insurance Society of Maryland, the Legal Mutual Liability Insurance Society of Maryland, and third party administrators; revising certain contingent provisions relating to the Maryland Health Insurance Reform Act; making certain technical corrections to certain provisions of the Insurance Article; conforming certain terminology in the Insurance Article; providing for the effective dates of this Act; and generally relating to the Insurance Article.

BY adding to
Article - Insurance
Section 2-109(c); 4-401 through 4-403, inclusive, to be under the new subtitle "Subtitle 4. Disclosure Requirements for Insurers"; 6-301 through 6-305, inclusive, to be under the new subtitle "Subtitle 3. Retaliation"; and 12-107
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the Acts of the General Assembly of 1995)

BY adding to
Article - Insurance
Section 10-121(l)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)

(As enacted by Chapter 36 of the Acts of the General Assembly of 1995, as amended by Chapter 635 of the Acts of the General Assembly of 1995, as amended by Chapters 206 and 239 of the Acts of the General Assembly of 1996)

BY adding to
Article - Insurance
Section 19-515 and 20-520
Annotated Code of Maryland
(1996 Volume)
(As enacted by Chapter 11 of the Acts of the General Assembly of 1996)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 1-101(t)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-103(d), 2-104(a)(2), 7-101, 8-101, and 8-313(b)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the Acts of the General Assembly of 1995)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 9-401(c) and (d)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 11 of the Acts of the General Assembly of 1996)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 10-121(b)(3)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the Acts of the General Assembly of 1995, as amended by Chapter 635 of the Acts of the General Assembly of 1995, as amended by Chapters 206 and 239 of the Acts of the General Assembly of 1996)

BY repealing and reenacting, with amendments,

Article - Insurance
Section 10-126(a)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the Acts of the General Assembly of 1995, as amended by Chapter 635 of the Acts of the General Assembly of 1995)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 16-105(b), 19-110, 20-101(i), 20-204(a)(2) and (b), 20-402, 20-405(a) and (c), and 20-406(a)(2)
Annotated Code of Maryland
(1996 Volume)
(As enacted by Chapter 11 of the Acts of the General Assembly of 1996)

BY adding to
Article - Insurance
Section 15-111
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 462, Section 3 of the Acts of the General Assembly of 1995 and by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY adding to
Article - Insurance
Section 24-207
Annotated Code of Maryland
(1996 Volume)
(As enacted by Chapter 50, Section 4 of the Acts of the General Assembly of 1995 and by Chapter 11 of the Acts of the General Assembly of 1996)

BY repealing and reenacting, with amendments, and transferring to the Session Laws
Article 48A - Insurance Code
Section 83(2), 88(1), 408A, 415, 490-O, 504(a)(2), 552(a), (b), and (c), 570(a), (b), (c), and (d), 573, 689(b)(3), and 702(b)(1)(i) and (ii)
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, with amendments, and transferring to the Session Laws
Article - Insurance
Section 10-118(a)(3)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 271, Section 2 of the Acts of the General Assembly of 1996)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Insurance

2-109.

(C) (1) BY REGULATION, THE COMMISSIONER SHALL ESTABLISH OR DIRECT THE ESTABLISHMENT OF A TOLL-FREE TELEPHONE NUMBER TO HELP CONSUMERS WITH AND EDUCATE CONSUMERS ABOUT THE PURCHASE OF PRIVATE PASSENGER AUTOMOBILE INSURANCE.

(2) THE COMMISSIONER:

(I) MAY NOT RECOMMEND SPECIFIC INSURERS OR AGENTS; BUT

(II) MAY PROVIDE TO CALLERS EDUCATIONAL MATERIAL, INCLUDING A RATE GUIDE AND A LIST OF INSURERS AND AGENTS.

REVISOR'S NOTE: This section formerly was Art. 48A, § 41C.
%The only changes are in style.

Defined terms: "Agent" § 1-101
"Commissioner" § 1-101
"Insurer" § 1-101

SUBTITLE 4. DISCLOSURE REQUIREMENTS FOR INSURERS.

4-401.

(A) THIS SECTION APPLIES TO:

(1) EACH INSURER THAT PROVIDES PROFESSIONAL LIABILITY INSURANCE TO:

(I) A PHYSICIAN, NURSE, DENTIST, PODIATRIST, OPTOMETRIST, OR CHIROPRACTOR LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE; OR

(II) A HOSPITAL LICENSED UNDER THE HEALTH - GENERAL ARTICLE; AND

(2) EACH SELF-INSURED HOSPITAL.

(B) AN ENTITY SUBJECT TO THIS SECTION SHALL REPORT QUARTERLY ANY CLAIM OR ACTION FOR DAMAGES FOR PERSONAL INJURY IF THE CLAIM OR ACTION:

(1) IS CLAIMED TO HAVE BEEN CAUSED BY AN ERROR, OMISSION, OR NEGLIGENCE IN THE PERFORMANCE OF THE INSURED'S PROFESSIONAL SERVICES OR IS BASED ON A CLAIMED PERFORMANCE OF THE INSURED'S PROFESSIONAL SERVICES WITHOUT CONSENT; AND

(2) RESULTED IN:

(I) A FINAL JUDGMENT IN ANY AMOUNT;

(II) A SETTLEMENT IN ANY AMOUNT; OR

(III) A FINAL DISPOSITION THAT DOES NOT RESULT IN PAYMENT ON BEHALF OF THE INSURED.

(C) A REPORT REQUIRED UNDER THIS SECTION SHALL CONTAIN:

(1) THE NAME AND ADDRESS OF THE INSURED;

(2) THE POLICY NUMBER OF THE INSURED;

(3) THE DATE OF THE OCCURRENCE FROM WHICH THE CLAIM OR ACTION AROSE;

(4) THE DATE OF FILING SUIT, IF ANY;

(5) THE DATE AND AMOUNT OF FINAL JUDGMENT OR SETTLEMENT, IF ANY;

(6) IF THERE IS NO FINAL JUDGMENT OR SETTLEMENT, THE DATE AND REASON FOR FINAL DISPOSITION;

(7) A SUMMARY OF THE OCCURRENCE FROM WHICH THE CLAIM OR ACTION AROSE; AND

(8) ANY OTHER INFORMATION AS MAY BE REQUIRED.

(D) A REPORT REQUIRED UNDER THIS SECTION SHALL BE FILED WITHIN 90 DAYS AFTER THE END OF THE QUARTER DURING WHICH AN EVENT DESCRIBED IN SUBSECTION (B)(2)(I), (II), OR (III) OF THIS SECTION OCCURRED.

(E) (1) A REPORT THAT RELATES TO A PHYSICIAN SHALL BE FILED WITH THE STATE BOARD OF PHYSICIAN QUALITY ASSURANCE.

(2) A REPORT THAT RELATES TO A HOSPITAL SHALL BE FILED WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE.

(3) A REPORT THAT RELATES TO A NURSE, DENTIST, PODIATRIST, OPTOMETRIST, OR CHIROPRACTOR SHALL BE FILED WITH THE APPROPRIATE LICENSING BOARD FOR THESE HEALTH CARE PROVIDERS.

(F) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A REPORT FILED IN ACCORDANCE WITH THIS SECTION SHALL BE TREATED AS A PERSONAL RECORD UNDER § 10-624(C) OF THE STATE GOVERNMENT ARTICLE.

(2) EACH REPORT SHALL BE RELEASED TO THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION.

(G) AN INSURER THAT REPORTS UNDER THIS SECTION OR ITS AGENTS OR EMPLOYEES, THE STATE BOARD OF PHYSICIAN QUALITY ASSURANCE OR ITS REPRESENTATIVES, AND ANY APPROPRIATE LICENSING AUTHORITY THAT RECEIVES A REPORT UNDER THIS SECTION SHALL HAVE THE IMMUNITY FROM LIABILITY DESCRIBED IN § 5-335 OF THE COURTS ARTICLE FOR ANY ACTION TAKEN BY THEM UNDER THIS SECTION.

(H) FAILURE TO REPORT IN ACCORDANCE WITH THIS SECTION SHALL RESULT IN THE IMPOSITION BY A CIRCUIT COURT OF A CIVIL PENALTY OF UP TO $5,000.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 490B.

In subsections (b) and (c)(3) and (7) of this section, the references to a claim or "action" are added for consistency throughout this section.

In subsection (e)(1) of this section, the term "physician" is substituted for the former obsolete term "practitioners of medicine".

In subsection (f)(1) of this section, the term "personal record" is substituted for the former reference to "confidential records" to conform to the terminology used in § 10-624 of the State Government Article.

In subsection (f)(2) of this section, former Art. 48A, § 490B (d)(2)(i), which required reports to be released to various licensing units, is deleted as unnecessary and obsolete in light of subsection (e) of this section, which requires the reports to be filed directly with the various licensing units rather than being released to them. These obsolete provisions occurred as the result of Chapter 638, Acts of 1986, which repealed a former requirement that the reports be filed initially with the Commissioner and then released to the licensing units and, instead, enacted the requirement that the reports be filed directly with the appropriate licensing units.

Defined term: "Insurer" § 1-101

4-402.

(A) MEDICAL FILES ON APPLICANTS AND CLAIMANTS THAT ARE COMPILED BY INSURERS UNDER POLICIES OF HEALTH INSURANCE OR LIFE INSURANCE SHALL BE MADE AVAILABLE FOR INSPECTION ON REQUEST OF THE APPLICANT OR CLAIMANT OR THE AGENT OF THE APPLICANT OR CLAIMANT.

(B) INFORMATION THAT IS PROVIDED BY A PHYSICIAN SHALL BE MADE AVAILABLE ON REQUEST:

(1) AFTER A PERIOD OF 5 YEARS AFTER THE DATE OF THE MEDICAL EXAMINATION; OR

(2) AT ANY TIME ON WRITTEN AUTHORIZATION OF THE PHYSICIAN.

(C) AN AGENT THAT REQUESTS TO REVIEW THE MEDICAL FILE OF AN APPLICANT OR CLAIMANT MUST HAVE AN AUTHORIZATION TO REVIEW MEDICAL RECORDS SIGNED BY THE APPLICANT OR CLAIMANT.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 490C.

In subsection (a) of this section, the defined term "insurer[s]" is substituted for the former reference to "insurance companies" to conform to the terminology used throughout this article.

In the introductory language of subsection (b) of this section, the requirement that information provided by a physician be "made" available is added for clarity.

In subsection (c) of this section, the reference to reviewing the medical file of an applicant or "claimant" is added for consistency within this section.

Defined terms: "Health insurance" § 1-101
"Insurer" § 1-101
"Life insurance" § 1-101
"Policy" § 1-101

4-403.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B), (C), OR (D) OF THIS SECTION, AN INSURER, OR AN INSURANCE SERVICE ORGANIZATION WHOSE FUNCTIONS INCLUDE THE COLLECTION OF MEDICAL DATA, MAY NOT DISCLOSE THE CONTENTS OF AN INSURED'S MEDICAL RECORDS.

(B) (1) AN INSURER MAY DISCLOSE SPECIFIC MEDICAL INFORMATION CONTAINED IN AN INSURED'S MEDICAL RECORDS TO THE INSURED OR THE INSURED'S AGENT OR REPRESENTATIVE.

(2) AN INSURER, OR AN INSURANCE SERVICE ORGANIZATION WHOSE FUNCTIONS INCLUDE THE COLLECTION OF MEDICAL DATA, MAY DISCLOSE SPECIFIC MEDICAL INFORMATION CONTAINED IN AN INSURED'S MEDICAL RECORDS IF THE INSURED AUTHORIZES THE DISCLOSURE.

(C) AN INSURER, OR AN INSURANCE SERVICE ORGANIZATION WHOSE FUNCTIONS INCLUDE THE COLLECTION OF MEDICAL DATA, MAY DISCLOSE THE CONTENTS OF AN INSURED'S MEDICAL RECORDS WITHOUT THE AUTHORIZATION OF THE INSURED:

(1) TO A MEDICAL REVIEW COMMITTEE, ACCREDITATION BOARD, OR COMMISSION, IF THE INFORMATION IS REQUESTED BY OR IS IN FURTHERANCE OF THE PURPOSE OF THE COMMITTEE, BOARD, OR COMMISSION;

(2) IN RESPONSE TO LEGAL PROCESS;

(3) TO A NONPROFIT HEALTH SERVICE PLAN OR BLUE CROSS OR BLUE SHIELD PLAN TO COORDINATE BENEFIT PAYMENTS UNDER MULTIPLE SICKNESS AND ACCIDENT, DENTAL, OR HOSPITAL MEDICAL CONTRACTS;

(4) TO INVESTIGATE POSSIBLE INSURANCE FRAUD;

(5) FOR REINSURANCE PURPOSES;

(6) IN THE NORMAL COURSE OF UNDERWRITING, TO AN INSURER INFORMATION EXCHANGE THAT MAY NOT REDISCLOSE THE INFORMATION UNLESS EXPRESSLY AUTHORIZED BY THE PERSON TO WHOM THE INFORMATION PERTAINS;

(7) TO EVALUATE AN APPLICATION FOR OR RENEWAL OF INSURANCE;

(8) TO EVALUATE AND ADJUST A CLAIM FOR BENEFITS UNDER A POLICY;

(9) TO EVALUATE, SETTLE, OR DEFEND A CLAIM OR SUIT FOR PERSONAL INJURY;

(10) IN ACCORDANCE WITH A COST CONTAINMENT CONTRACTUAL OBLIGATION TO VERIFY THAT BENEFITS PAID BY THE INSURER WERE PROPER CONTRACTUALLY; OR

(11) TO A POLICYHOLDER IF:

(I) THE POLICYHOLDER DOES NOT FURTHER DISCLOSE THE SPECIFIC MEDICAL INFORMATION; AND

(II) THE INFORMATION IS REQUIRED FOR AN AUDIT OF THE BILLING MADE BY THE INSURER TO THE POLICYHOLDER.

(D) THIS SECTION DOES NOT PROHIBIT THE USE OF MEDICAL RECORDS, DATA, OR STATISTICS IF THE USE DOES NOT DISCLOSE THE IDENTITY OF A PARTICULAR INSURED OR COVERED PERSON.

(E) AN INSURER THAT KNOWINGLY VIOLATES THIS SECTION IS LIABLE TO A PLAINTIFF FOR ANY DAMAGES RECOVERABLE IN A CIVIL ACTION, INCLUDING REASONABLE ATTORNEY'S FEES.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 490E.

In subsections (a), (b)(1) and (2), the introductory language of (c), and (e) of this section, the former references to an "insurance company" are deleted as included in the defined term "insurer". Similarly, in subsection (c)(10) and (11)(ii) of this section, the defined term "insurer" is substituted for the former words "insurance carrier" for consistency with terminology used in this article.

In subsections (a), (b)(1) and (2), the introductory language of (c), and (c)(11)(i) of this section, the word "disclose" is substituted for the former word "reveal" for consistency with terminology used in Title 4, Subtitle 3 of the Health - General Article ("Confidentiality of Medical Records").

In subsection (a) of this section, the former phrase "to any person" is deleted as surplusage.

In subsections (b)(1) and (2) and the introductory language of (c) of this section, the reference to the "insured's" medical records is substituted for the former reference to a "person's" medical records for specificity and consistency within this section.

In the introductory language of subsection (c) of this section, the phrase "without the authorization of the insured" states expressly that which was only implied in the former law.

In subsection (e) of this section, the reference to damages recoverable in a

"civil action" is substituted for the former reference to damages recoverable "in law or equity" to reflect the 1984 revision of the Maryland Rules, which eliminated the pleading distinctions between law and equity.

The Insurance Article Review Committee notes, for consideration by the General Assembly, that former Art. 48A, § 490E was first enacted in 1978 as part of an act (Chapter 728) relating to privacy of medical records that also enacted similar provisions in the former Health Article. The Committee also notes that the provisions of the Health - General Article relating to confidentiality of medical records were substantively revised in 1990 (Chapter 480). The General Assembly may wish to consider whether this section should also be substantively revised to ensure consistency with Title 4, Subtitle 3 of the Health - General Article.

Defined terms: "Agent" § 1-101
"Insurer" § 1-101
"Person" § 1-101

SUBTITLE 3. RETALIATION.

6-301.

(A) THIS SUBTITLE DOES NOT APPLY TO:

(1) PERSONAL INCOME TAXES;

(2) AD VALOREM TAXES ON REAL OR PERSONAL PROPERTY;

(3) SPECIAL PURPOSE OBLIGATIONS OR ASSESSMENTS IMPOSED BY ANOTHER STATE IN CONNECTION WITH PARTICULAR KINDS OF INSURANCE OTHER THAN PROPERTY INSURANCE; OR

(4) ASSESSMENTS IMPOSED BY INSURANCE GUARANTY ASSOCIATIONS OR SIMILAR ORGANIZATIONS IN ANOTHER STATE.

(B) NOTWITHSTANDING SUBSECTION (A) OF THIS SECTION, IN DETERMINING THE PROPRIETY AND EXTENT OF RETALIATORY ACTION UNDER THIS SUBTITLE, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION DEDUCTIONS FROM PREMIUM TAXES OR OTHER TAXES OTHERWISE PAYABLE, ALLOWED FOR REAL OR PERSONAL PROPERTY TAXES PAID.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 61(2).

Defined terms: "Commissioner" § 1-101
"Property insurance" § 1-101
"State" § 1-101

6-302.

FOR PURPOSES OF THIS SUBTITLE, THE DOMICILE OF AN ALIEN INSURER IS:

(1) FOR AN ALIEN INSURER FORMED UNDER THE LAWS OF CANADA OR A PROVINCE OF CANADA, THE PROVINCE IN WHICH ITS HEAD OFFICE IS LOCATED; AND

(2) FOR ANY OTHER ALIEN INSURER, THE STATE IN WHICH ITS PRINCIPAL PLACE OF BUSINESS IN THE UNITED STATES IS LOCATED.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 61(3) and (4).

Defined terms: "Alien insurer" § 1-101
"State" § 1-101

6-303.

(A) WHEN BY OR PURSUANT TO THE LAWS OF ANY OTHER STATE OR FOREIGN COUNTRY ANY TAXES, LICENSES AND OTHER FEES, IN THE AGGREGATE, AND ANY FINES, PENALTIES, DEPOSIT REQUIREMENTS OR OTHER MATERIAL OBLIGATIONS, PROHIBITIONS OR RESTRICTIONS ARE OR WOULD BE IMPOSED UPON MARYLAND INSURERS, OR UPON THE AGENTS OR REPRESENTATIVES OF SUCH INSURERS, WHICH ARE IN EXCESS OF SUCH TAXES, LICENSES AND OTHER FEES, IN THE AGGREGATE, OR WHICH ARE IN EXCESS OF THE FINES, PENALTIES, DEPOSIT REQUIREMENTS OR OTHER OBLIGATIONS, PROHIBITIONS, OR RESTRICTIONS DIRECTLY IMPOSED UPON SIMILAR INSURERS, OR UPON THE AGENTS OR REPRESENTATIVES OF SUCH INSURERS, OF SUCH OTHER STATE OR COUNTRY UNDER THE STATUTES OF THIS STATE, SO LONG AS SUCH LAWS OF SUCH OTHER STATE OR COUNTRY CONTINUE IN FORCE OR ARE SO APPLIED, THE SAME TAXES, LICENSES AND OTHER FEES, IN THE AGGREGATE, OR FINES, PENALTIES OR DEPOSIT REQUIREMENTS OR OTHER MATERIAL OBLIGATIONS, PROHIBITIONS, OR RESTRICTIONS OF WHATEVER KIND SHALL BE IMPOSED BY THE COMMISSIONER UPON THE INSURERS, OR UPON THE AGENTS OR REPRESENTATIVES OF SUCH INSURERS, OF SUCH OTHER STATE OR COUNTRY DOING BUSINESS OR SEEKING TO DO BUSINESS IN MARYLAND.

(B) FOR THE PURPOSES OF THIS SUBTITLE, ANY TAX, LICENSE OR OTHER FEE OR OTHER OBLIGATION IMPOSED BY A POLITICAL SUBDIVISION OR AGENCY OF ANOTHER STATE OR COUNTRY UPON MARYLAND INSURERS OR THEIR AGENTS OR REPRESENTATIVES SHALL BE DEEMED TO BE IMPOSED BY THAT STATE OR COUNTRY.

REVISOR'S NOTE: This section formerly was the first and second sentences of former Art. 48A, § 61(1).
No changes are made in subsection (a) of this section.
The only changes made in subsection (b) of this section are in style.

Defined terms: "Agent" § 1-101
"Commissioner" § 1-101

"Insurer" § 1-101
"State" § 1-101

6-304.

ALL TAXES IMPOSED BY THIS SUBTITLE THAT ARE NOT PAID WITHIN 30 DAYS AFTER THE COMMISSIONER ISSUES THE NOTICE OF THE AMOUNT DUE ARE SUBJECT TO A PENALTY OF 5% AND INTEREST AT THE RATE DETERMINED UNDER § 13-604 OF THE TAX - GENERAL ARTICLE FOR EACH MONTH AFTER THE DATE OF THE NOTICE THAT THE TAX WAS DUE.

REVISOR'S NOTE: This section formerly was the third sentence of former Art. 48A, § 61(1).
The only changes are in style.

Defined term: "Commissioner" § 1-101

6-305.

UNLESS THE ADMINISTRATION AND THE CENTRAL COLLECTION UNIT OF THE DEPARTMENT OF BUDGET AND MANAGEMENT AGREE OTHERWISE, THE ADMINISTRATION MAY NOT REFER TO THE UNIT ANY ACTION TO RECOVER MONEY UNDER THIS SUBTITLE.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 61(5).
The references to the "Administration" are substituted for the former references to the "Department of Labor, Licensing, and Regulation" for accuracy.

Defined term: "Administration" § 1-101

10-121.

(L) IN ADDITION TO ANY REQUIREMENTS UNDER TITLE 10, SUBTITLE 1 OF THIS ARTICLE, TITLE INSURANCE AGENTS AND TITLE INSURANCE BROKERS SHALL COMPLY WITH THIS SECTION.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 168A(b).
%The only changes are in style.

12-107.

(A) NOTWITHSTANDING ANY PROVISION OF THIS ARTICLE OR OTHER LAW THAT SPECIFIES THE CONTENT OF POLICIES, THE COMMISSIONER MAY APPROVE AND INSURERS MAY ISSUE SIMPLIFIED POLICIES OF INSURANCE THAT PROVIDE BROAD COVERAGE OF ALL OR VARIOUS COMBINATIONS OF RISKS.

(B) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) SPECIFY THE STANDARDS THAT MUST BE MET BY INSURERS FOR ISSUING SIMPLIFIED POLICIES; AND

(2) ENSURE PROTECTIONS TO POLICYHOLDERS AND CLAIMANTS THAT ARE NOT LESS FAVORABLE THAN PROTECTIONS TO WHICH THEY WOULD BE ENTITLED UNDER A SUBSTANTIALLY SIMILAR POLICY THAT IS NOT SUBJECT TO THIS SECTION.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 490D.

Defined terms: "Commissioner" § 1-101
"Insurance" § 1-101
"Insurer" § 1-101
"Policy" § 1-101

19-515.

AN INSURER MAY NOT REFUSE TO ISSUE OR RENEW A MOTOR VEHICLE LIABILITY INSURANCE POLICY UNDER THIS SUBTITLE ON THE GROUND THAT THE APPLICANT HAS BEEN ISSUED A CITATION UNDER § 3-835 OF THE COURTS ARTICLE.

REVISOR'S NOTE: This section formerly was Art. 48A, § 547A.
%The only changes are in style.

Defined term: "Insurer" § 1-101

20-520.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, AN INSURER THAT ISSUES, SELLS, OR DELIVERS PRIVATE PASSENGER MOTOR VEHICLE INSURANCE IN THE STATE MAY NOT REFUSE TO ISSUE A POLICY OF PRIVATE PASSENGER MOTOR VEHICLE INSURANCE TO ANY PERSON WHO, FOR THE IMMEDIATELY PRECEDING 3 CONTINUOUS YEARS:

(1) HAS BEEN INSURED BY THE FUND;

(2) HAS NOT HAD A MOVING TRAFFIC VIOLATION; AND

(3) HAS NOT HAD A CHARGEABLE TRAFFIC ACCIDENT.

(B) SUBJECT TO § 27-501 OF THIS ARTICLE, AN INSURER MAY REFUSE TO ISSUE A POLICY UNDER SUBSECTION (A) OF THIS SECTION IF THE PERSON DOES NOT SATISFY THE INSURER'S ELIGIBILITY OR UNDERWRITING STANDARDS.

(C) A PERSON WHO IS ENTITLED TO INSURANCE UNDER SUBSECTION (A) OF THIS SECTION:

(1) SHALL BE RATED BY THE INSURER IN THE SAME MANNER AS ANY OTHER POLICYHOLDER NOT PREVIOUSLY INSURED BY THE FUND HAVING THE SAME RISK CHARACTERISTICS; AND

(2) MAY NOT BE SURCHARGED OR RATED BY THE INSURER SOLELY BECAUSE THE PERSON WAS INSURED BY THE FUND.

(D) (1) AT LEAST 60 DAYS BEFORE EXPIRATION OR RENEWAL OF A POLICY OF PRIVATE PASSENGER MOTOR VEHICLE INSURANCE, THE FUND SHALL PROVIDE

WRITTEN NOTICE TO EACH PERSON ENTITLED TO INSURANCE UNDER SUBSECTION (A) OF THIS SECTION.

(2) THE NOTICE SHALL:

(I) INFORM THE PERSON OF THE PERSON'S RIGHT TO INSURANCE UNDER SUBSECTION (A) OF THIS SECTION;

(II) ADVISE THE PERSON TO CONTACT THE PRODUCER THAT BOUND THE PERSON'S COVERAGE WITH THE FUND DURING THE MOST RECENT COVERAGE PERIOD;

(III) INCLUDE A COPY OF A SAMPLE RATE GUIDE PRODUCED BY THE ADMINISTRATION; AND

(IV) PROVIDE THE TOLL-FREE TELEPHONE NUMBER ESTABLISHED UNDER § 2-109 OF THIS ARTICLE.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, §§ 243-O and 243P.

Defined terms: "Administration" § 1-101
"Fund" § 20-101
"Insurance" § 1-101
"Insurer" § 1-101
"Person" §§ 1-101 and 20-101
"Policy" § 1-101
"Producer" § 20-101

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Insurance

1-101.

(t) ["Insurance"] EXCEPT AS EXPRESSLY PROVIDED OTHERWISE IN THIS ARTICLE, "INSURANCE" means a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency.

2-103.

(d) The Commissioner is [in the unclassified service of the State Personnel Management System] UNCLASSIFIED and is entitled to compensation under the [Executive Pay Plan] EXECUTIVE COMPENSATION PLAN in accordance with the State budget.

2-104.

(a) (2) The Deputy Commissioner is [in the unclassified service of the State Personnel Management System] UNCLASSIFIED and is entitled to ANNUAL compensation in accordance with the State budget.

7-101.

(a) In this title the following words have the meanings indicated.

(b) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(C) "CONTROL", "CONTROLLING", "CONTROLLED BY", OR "UNDER COMMON CONTROL WITH" MEANS THE DIRECT OR INDIRECT POSSESSION OF THE POWER TO DIRECT OR CAUSE THE DIRECTION OF THE MANAGEMENT AND POLICIES OF A PERSON, THROUGH OWNERSHIP OF VOTING SECURITIES OR OF SECURITIES CONVERTIBLE INTO VOTING SECURITIES, BY CONTRACT OTHER THAN A COMMERCIAL CONTRACT FOR GOODS OR NONMANAGEMENT SERVICES, OR OTHERWISE, WHETHER OR NOT THE POWER IS EXERCISED OR SOUGHT TO BE EXERCISED.

[(c)] (D) "Insurance holding company" means a person that directly or indirectly controls an insurer or controls a person that controls an insurer.

[(d)] (E) "Insurance holding company system" means two or more affiliates, at least one of which is an insurer.

[(e)] (F) "Subsidiary" means an affiliate of a person that, directly or indirectly, through one or more intermediaries, is controlled by that person.

8-101.

(a) In this subtitle the following words have the meanings indicated.

(B) "CONTROL", "CONTROLLING", "CONTROLLED BY", OR "UNDER COMMON CONTROL WITH" MEANS THE DIRECT OR INDIRECT POSSESSION OF THE POWER TO DIRECT OR CAUSE THE DIRECTION OF THE MANAGEMENT AND POLICIES OF A PERSON, THROUGH OWNERSHIP OF VOTING SECURITIES OR OF SECURITIES CONVERTIBLE INTO VOTING SECURITIES, BY CONTRACT OTHER THAN A COMMERCIAL CONTRACT FOR GOODS OR NONMANAGEMENT SERVICES, OR OTHERWISE, WHETHER OR NOT THE POWER IS EXERCISED OR SOUGHT TO BE EXERCISED.

[(b)] (C) "Controlled insurer" means an insurer that is under the control of a controlling broker.

[(c)] (D) "Controlling broker" means a broker that has control of a controlled insurer.

8-313.

(b) An administrator that fails to provide advance notice under subsection (a) of this section shall honor and pay in full[, for 30 days after the postmarked date of the notice,] any claim under the program rules or requirements that existed before the change FOR 30 DAYS AFTER THE POSTMARKED DATE OF THE NOTICE.

9-401.

[(c)] (D) "Corporation" means the Life and Health Insurance Guaranty Corporation.

[(d)] (C) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract for which coverage is provided under § 9-403 of this subtitle.

10-121.

(b) (3) If an applicant for a certificate of qualification is a limited liability company, each individual who has direct control over its fiscal management and each [member, manager, officer, and director] MANAGER AND OFFICER must hold a certificate of qualification to act as a title insurance agent or title insurance broker and, if applicable, an appointment with a title insurer.

10-126.

(a) [Subject to the hearing provisions of Title 2 of this article, the] THE Commissioner may deny a certificate of qualification to an applicant UNDER THE PROVISIONS OF §§ 2-210 THROUGH 2-214 OF THIS ARTICLE or suspend, revoke, or refuse to renew a certificate of qualification AFTER NOTICE AND HEARING IN ACCORDANCE WITH THE PROVISIONS OF §§ 2-210 THROUGH 2-214 OF THIS ARTICLE if the applicant or holder of the certificate of qualification:

(1) has willfully violated this article or another law of the State that relates to insurance;

(2) has intentionally misrepresented or concealed a material fact in the application for a certificate of qualification;

(3) has obtained or attempted to obtain a certificate of qualification by misrepresentation, concealment, or other fraud;

(4) has misappropriated, converted, or unlawfully withheld money belonging to an insurer, agent, broker, beneficiary, or insured;

(5) has willfully and materially misrepresented the provisions of a policy;

(6) has committed fraudulent or dishonest practices in the insurance business;

(7) has participated, with or without the knowledge of an insurer, in selling motor vehicle insurance without an actual intent to sell the insurance, as evidenced by a persistent pattern of filing certificates of insurance together with or closely followed by cancellation notices for the insurance;

(8) has been convicted by final judgment in any state or federal court of a crime involving moral turpitude;

(9) has knowingly participated in writing or issuing substantial over-insurance of property insurance risks;

(10) has failed an examination required by this subtitle;

(11) has willfully failed to comply with or has willfully violated a proper order or regulation of the Commissioner;

(12) has failed or refused to pay over on demand money that belongs to an insurer, agent, broker, or other person entitled to the money;

(13) has otherwise shown a lack of trustworthiness or competence to act as an agent or broker;

(14) is not or does not intend to carry on business in good faith and represent to the public that the person is an agent or broker;

(15) has been denied a license or certificate in another state or has had a license or certificate suspended or revoked in another state;

(16) has intentionally or willfully made or issued, or caused to be made or issued, a statement that materially misrepresents or makes incomplete comparisons about the terms or conditions of a policy or contract issued by an authorized insurer, for the purpose of inducing or attempting to induce the owner of the policy or contract to forfeit or surrender it or allow it to lapse in order to replace it with another;

(17) has transacted insurance business that was directed to the applicant or holder for consideration by a person whose license or certificate to engage in the insurance business at the time was suspended or revoked, and the applicant or holder knew or should have known of the suspension or revocation;

(18) has solicited, procured, or negotiated insurance contracts for an unauthorized insurer, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations; or

(19) has knowingly employed or knowingly continued to employ an individual acting in a fiduciary capacity who has been convicted of a felony or crime of moral turpitude within the preceding 10 years.

16-105.

(b) Each policy of life insurance or annuity contract subject to this title shall have attached to or prominently printed on its face the FOLLOWING information:

(1) a notice to the policyholder that:

(i) for 10 days after the date the policy or annuity contract is delivered to the policyholder, the policyholder may surrender the policy or annuity contract to the insurer for cancellation by giving the insurer written notice of cancellation; and

(ii) the insurer shall return to the policyholder a pro rata premium for the unexpired term of the policy or annuity contract; or

(2) a similar notice to the policyholder that in the opinion of the Commissioner is not less favorable to the policyholder.

19-110.

An insurer may disclaim coverage on a liability insurance policy on the ground that the insured or a person claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the insurer or by not giving the insurer required notice only if the insurer establishes by a preponderance of the evidence that the lack of cooperation or notice has resulted in ACTUAL prejudice to the insurer.

20-101.

(i) ["Physical damage insurance"] "MOTOR VEHICLE PHYSICAL DAMAGE INSURANCE" means insurance coverage that is reported as private passenger auto physical damage or commercial auto physical damage on the exhibit of premiums and losses page of the annual statement that Association members are required to file with the Commissioner.

20-204.

(a) (2) Positions that the Executive Director designates with the approval of the Board of Trustees as EXECUTIVE, MANAGEMENT, technical or professional positions [are in the unclassified service of the State Personnel Management System] ARE DEEMED SPECIAL APPOINTMENTS WITHIN THE MEANING OF § 6-405 OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(b) The Executive Director shall determine the compensation of [the unclassified service] SPECIAL APPOINTMENT personnel of the Fund:

(1) with the approval of the Board of Trustees; and

(2) when possible, in accordance with the State pay plan.

20-402.

(a) The Association consists of all insurers except for the Fund that are licensed to write on a direct basis motor vehicle liability insurance or MOTOR VEHICLE physical damage insurance in the State.

(b) As a condition of its authority to write motor vehicle liability insurance or MOTOR VEHICLE physical damage insurance in the State, an insurer must be and remain an Association member.

20-405.

(a) In this section, "net direct written premiums" means direct gross premiums written on all policies of motor vehicle liability insurance and MOTOR VEHICLE physical damage insurance less return premiums or dividends paid or credited to policyholders with respect to those policies.

(c) The Board of Directors shall obtain from the Commissioner the aggregate net direct written premiums of all Association members during the most recent calendar year determined by the Commissioner for commercial auto and private passenger auto divisions of motor vehicle liability insurance and MOTOR VEHICLE physical damage insurance.

20-406.

(a) (2) Unless the Commissioner finds the calculation to be inaccurate, the Commissioner shall authorize each Association member to impose an assessment surcharge on each policy of motor vehicle liability insurance or MOTOR VEHICLE physical damage insurance that is written or renewed in the State during the 1-year period beginning on the next July 1 following notice of the assessment.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Insurance

15-111.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15-1201 OF THIS TITLE.

(3) "PAYOR" MEANS:

(I) A HEALTH INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT HOLDS A CERTIFICATE OF AUTHORITY AND PROVIDES HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE UNDER THIS ARTICLE;

(II) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE; OR

(III) A THIRD PARTY ADMINISTRATOR OR ANY OTHER ENTITY UNDER CONTRACT WITH A MARYLAND BUSINESS TO ADMINISTER HEALTH CARE BENEFITS.

(B) (1) ON OR BEFORE JUNE 30 OF EACH YEAR, THE COMMISSIONER SHALL ASSESS EACH PAYOR A FEE FOR THE NEXT FISCAL YEAR.

(2) THE FEE SHALL BE ESTABLISHED IN ACCORDANCE WITH THIS SECTION AND § 19-1515 OF THE HEALTH - GENERAL ARTICLE.

(C) (1) FOR EACH FISCAL YEAR, THE TOTAL ASSESSMENT FOR ALL PAYORS SHALL BE:

(I) SET BY A MEMORANDUM FROM THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION; AND

(II) APPORTIONED EQUITABLY BY THE COMMISSIONER AMONG THE CLASSES OF PAYORS DESCRIBED IN SUBSECTION (A)(3) OF THIS SECTION AS DETERMINED BY THE COMMISSIONER.

(2) OF THE TOTAL ASSESSMENT APPORTIONED UNDER PARAGRAPH (1) OF THIS SUBSECTION TO PAYORS DESCRIBED IN SUBSECTION (A)(3)(I) OF THIS SECTION, THE COMMISSIONER SHALL ASSESS EACH PAYOR A FRACTION:

(I) THE NUMERATOR OF WHICH IS THE PAYOR'S TOTAL PREMIUMS COLLECTED IN THE STATE FOR HEALTH BENEFIT PLANS FOR AN APPROPRIATE PRIOR 12-MONTH PERIOD AS DETERMINED BY THE COMMISSIONER; AND

(II) THE DENOMINATOR OF WHICH IS THE TOTAL PREMIUMS COLLECTED IN THE STATE FOR THE SAME PERIOD FOR HEALTH BENEFIT PLANS OF ALL PAYORS DESCRIBED IN SUBSECTION (A)(3)(I) OF THIS SECTION.

(3) OF THE TOTAL ASSESSMENT APPORTIONED UNDER PARAGRAPH (1) OF THIS SUBSECTION TO PAYORS DESCRIBED IN SUBSECTION (A)(3)(II) OF THIS SECTION, THE COMMISSIONER SHALL ASSESS EACH PAYOR A FRACTION:

(I) THE NUMERATOR OF WHICH IS THE PAYOR'S TOTAL ADMINISTRATIVE FEES COLLECTED IN THE STATE FOR HEALTH BENEFIT PLANS FOR AN APPROPRIATE PRIOR 12-MONTH PERIOD AS DETERMINED BY THE COMMISSIONER; AND

(II) THE DENOMINATOR OF WHICH IS THE TOTAL ADMINISTRATIVE FEES COLLECTED IN THE STATE FOR HEALTH BENEFIT PLANS FOR THE SAME PERIOD OF ALL PAYORS DESCRIBED IN SUBSECTION (A)(3)(II) OF THIS SECTION.

(D) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, EACH PAYOR THAT IS ASSESSED A FEE UNDER THIS SECTION SHALL PAY THE FEE TO THE COMMISSIONER ON OR BEFORE SEPTEMBER 1 OF EACH YEAR.

(2) THE COMMISSIONER, IN COOPERATION WITH THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION, MAY PROVIDE FOR PARTIAL PAYMENTS.

(E) THE COMMISSIONER SHALL DISTRIBUTE THE FEES COLLECTED UNDER THIS SECTION TO THE HEALTH CARE ACCESS AND COST FUND ESTABLISHED UNDER § 19-1515 OF THE HEALTH - GENERAL ARTICLE.

(F) EACH PAYOR SHALL COOPERATE FULLY IN SUBMITTING REPORTS AND CLAIMS DATA AND PROVIDING ANY OTHER INFORMATION TO THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION IN ACCORDANCE WITH TITLE 19, SUBTITLE 15 OF THE HEALTH - GENERAL ARTICLE.

(G) EACH PAYOR SHALL PAY FOR HEALTH CARE SERVICES IN ACCORDANCE WITH THE PAYMENT SYSTEM ADOPTED UNDER § 19-1509 OF THE HEALTH - GENERAL ARTICLE.

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Insurance

24-207.

(A) EACH POLICYHOLDER IS SUBJECT TO ASSESSMENT AS PROVIDED IN §§ 3-110, 3-111, AND 3-112 OF THIS ARTICLE.

(B) NOTWITHSTANDING SUBSECTION (A) OF THIS SECTION, IF THE SOCIETY MEETS ALL APPLICABLE REQUIREMENTS OF THIS ARTICLE ABOUT THE SALE OF NONASSESSABLE POLICIES, INCLUDING THE REQUIREMENTS OF §§ 4-104, 4-105, AND 4-106 OF THIS ARTICLE, THE SOCIETY MAY ISSUE NONASSESSABLE POLICIES SUBJECT TO:

(1) § 3-333 OF THIS ARTICLE;

(2) ALL OTHER APPLICABLE PROVISIONS OF THIS ARTICLE; AND

(3) THE CORPORATIONS AND ASSOCIATIONS ARTICLE.

SECTION 5. AND BE IT FURTHER ENACTED, That Section(s) 83(2) and 415 of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

POLICIES AND CONTRACTS ISSUED BEFORE OPERATIVE DATE OF STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

[83.] 1.

[(2)] This [subsection] SECTION shall apply only to those policies and contracts issued prior to the operative date of [§ 414 (the Standard Nonforfeiture Law for Life Insurance)] THE MARYLAND STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE.

The net value of all policies issued on or before the thirty-first day of December, in the year nineteen hundred and two, shall be based upon the American Experience Table of Mortality, and four and one-half percent interest per annum; and for all policies issued subsequent to said thirty-first day of December, in the year nineteen hundred and two, and on or before the thirty-first day of December, in the year nineteen hundred and eighteen, upon the Actuaries Table of Mortality and four percent interest per annum; and for all policies except industrial issued subsequent to the thirty-first day of December in the year nineteen hundred and eighteen, upon the American Experience Table of Mortality or the American Men Ultimate Table of Mortality and three and one-half percent interest per annum; provided, that the Commissioner shall, upon the request of any insurer, cause all policies of such insurer, issued subsequent to the thirty-first day of December, in the year nineteen hundred and eighteen, to be valued in accordance with the terms of the policy contract, but in no case to be less than that determined by the one-year preliminary term method of valuation, as hereinafter modified, on the basis of the American Experience Table of Mortality or the American Men Ultimate Table of Mortality and three and one-half percent interest per annum. If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than twenty years from the date of the policy, or under an endowment preliminary term policy, exceeds that charged for like insurance under twenty-payment life preliminary term policies of the same insurer, the reserve thereon at the end of any year, including the first, shall not be less than the reserve of a twenty-payment life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of such period of such a

twenty-payment life preliminary term policy and the full net level premium reserve at such time of such a limited payment life or endowment policy. The premium payment period is the period during which premiums are concurrently payable. The value of all policies which contain any promise or agreement for the purchase of the policy at any date prior to its maturity or its termination by death for a sum in excess of the value of the policy at such date determined according to the standard of valuation herein prescribed for such policy, shall be calculated in such manner and upon such assumption as to the rate of interest and mortality, that the value of the policy so calculated shall at no time be less than the amount stipulated therein, to be paid upon surrender of the policy at the date then attained, and for the purpose of such valuation the standard adopted by the insurer for the value of such obligation may, if adequate, be employed.

The legal minimum standard for valuation of industrial policies issued subsequent to the thirty-first day of December, in the year nineteen hundred and eighteen, shall be the American Experience Table of Mortality, with three and one-half percent interest per annum, according to the net level premium method or in accordance with their terms by the modified preliminary term method hereinabove described, provided, that any insurer may value its industrial policies on the basis of the Standard Industrial or the Substandard Industrial Mortality Table, or such other table or tables of mortality as may be approved by the Commissioner, according to the net level premium method, or in accordance with their terms by the modified preliminary term method hereinabove described.

The Commissioner may, in his discretion, upon the request of any life insurer so reporting to him, cause the net value of all or any number of policies in force in such insurer to be calculated upon a higher basis of reserve than that prescribed above by the assumption of a lower rate of interest than that prescribed, or the assumption of a higher rate of mortality by the substitution of the Actuaries Table of Mortality for the American Experience Table of Mortality or otherwise as the circumstances of the case may require; provided, that in no case shall the net value so ascertained and taken as a basis of reserve be less than that determined by the standard of valuation above prescribed; and in every certificate of the valuation of policies issued by the Commissioner the basis upon which the valuation is calculated shall be stated, if so requested by the insurer.

REVISOR'S NOTE: This section formerly was Art. 48A, § 83(2).

%Depending on the insurer's election and possible extension by the Commissioner, the operative date of the Maryland Standard Nonforfeiture Law for Life Insurance is a date after June 1, 1947, but not later than December 31, 1949. The reserves required for policies and contracts issued before that date have long been set and neither the minimum reserves required nor the reserves established by insurers for these policies and contracts are subject to further change (with the exception of possible reduction, under certain circumstances, of reserves with the Commissioner's approval under § 5-301(d) of the Insurance Article). The Insurance Article Review Committee decided that in view of its limited and diminishing applicability, the former provision should not be revised in the Insurance Article. However, as policies and contracts issued before the operative date of the Maryland Standard Nonforfeiture Law for Life Insurance remain in effect, the former provision clearly is not obsolete at this time. Therefore, the

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provision is transferred to the Session Laws.
The only changes are in style.

[415.] 2.

(a) This section shall apply only to policies of industrial life insurance issued prior to the operative date of [§ 414 (Standard Nonforfeiture Law) of this subtitle]THE MARYLAND STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE.

(b) A nonforfeiture benefit shall be available to the insured in event of default in premium payments, after premiums shall have been paid for five full years, and shall be a stipulated form of insurance effective from the due date of the defaulted premium, the net value of which stipulated form of insurance shall not be less than the reserve on the policy at the end of the last completed quarter of the policy year for which premiums have been paid, and on dividend additions thereto, if any, exclusive of any reserve on total and permanent disability and additional accidental death benefits (the policy to specify the mortality table, rate of interest and method of valuation adopted for computing such reserve, if other than the net level-premium method), less a specified maximum percentage (not more than two and one-half) of the maximum amount insured by the policy and of existing dividend additions thereto, if any, and less any existing indebtedness to the insurer on or secured by the policy. Provided, however, that after premiums have been paid for ten full years, the policy may be surrendered to the insurer at its home office, within the period of grace, after the due date of the defaulted premium, for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid; and provided, further, that the company may defer payment for not more than six months after the application therefor is made. In the event that such application is not made within the required period, it shall be provided that a stipulated form of insurance shall automatically become effective. This section shall not apply to term insurance of twenty years or less.

REVISOR'S NOTE: This section formerly was Art. 48A, § 415.
%Former Art. 48A, § 415 governed nonforfeiture benefits under industrial life insurance policies issued for terms longer than 20 years before the operative date of the Maryland Standard Nonforfeiture Law for Life Insurance. Because of its limited and diminishing applicability, it is transferred to the Session Laws.
The only changes are in style.

SECTION 6. AND BE IT FURTHER ENACTED, That Section(s) 408A of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

INDIVIDUAL ANNUITIES ISSUED BEFORE OPERATIVE DATE OF STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

[408A.] 1.

(a) In the case of annuities other than those covered by subsection (c), there shall be a provision that, in the event of default, in premium payments after three full years'

premiums have been paid, the annuity shall, without any further act or stipulation, be converted into a paid-up annuity for such proportion of the original annuity as the number of completed years' premiums paid bears to the total number of premiums required under the contract, or into a paid-up annuity of an amount, if greater, which is the actuarial equivalent of any cash surrender value required under subsection (b).

(b) In the case of annuities other than those covered by subsection (c), there shall be a provision that, in the event of default in premium payments, the contract holder shall have the option of surrendering the contract for its cash surrender value prior to the date of commencement of annuity payments. The cash surrender value as of the date of default shall not be less than an amount determined as follows: in the event of default in premium payments (1) at any time during the first contract year, 60 percent of all considerations paid under the contract; (2) at the end of the second contract year, 70 percent of all considerations paid under the contract; (3) at the end of the third contract year, 73 1/3 percent of all considerations paid under the contract; (4) at any time during the second or third contract year, other than at the end of the second or third year, the sum of 60 percent of all considerations paid under the contract during the first contract year, plus 80 percent of all considerations paid after the first contract year; and (5) after the third contract year, the actuarial equivalent, on a basis stated in the policy and approved by the Commissioner, of any paid-up annuity required under subsection (a). The cash surrender value at any time after the date of default but prior to the date of commencement of annuity payments shall be not less than the cash surrender value specified in the contract as of the date of default increased by interest to the date of surrender, at a rate specified in the policy and approved by the Commissioner.

(c) In the case of annuities under which the period of premium payments extends beyond the date of commencement of annuity payments and in the case of any other annuities for which the requirements of subsections (a) and (b) are in the opinion of the Commissioner inequitable, there shall be provision for nonforfeiture benefits, in the event of default in premium payments, which in the opinion of the Commissioner are equitable to the holder of the contract.

(d) This section shall apply to only those individual annuities issued prior to the operative date of [§ 408B (The Standard Nonforfeiture Law for Individual Deferred Annuities)] THE MARYLAND STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES.

REVISOR'S NOTE: This section formerly was Art. 48A, § 408A.
%Former Art. 48A, § 408A governed annuities issued before July 1, 1980, which is the effective date of the Maryland Standard Nonforfeiture Law for Individual Deferred Annuities. Because of its limited and diminishing applicability, it is transferred to the Session Laws.
The only changes are in style.

SECTION 7. AND BE IT FURTHER ENACTED, That Section(s) 88(1) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

ELIGIBILITY OF INVESTMENTS OF LIFE INSURERS

[88.] 1.

[(1)] Any particular investment held by an insurer on December 31, 1963, and which was an authorized investment at the time it was made, or which would be an authorized investment under the provisions of [this article] THE INSURANCE ARTICLE, shall be deemed to be an eligible investment.

REVISOR'S NOTE: This section formerly was Art. 48A, § 88(1).
%Former Art. 48A, § 88(1) provided for the eligibility of investments held by an insurer on December 31, 1963. Although this provision was transitory in effect and the intended purposes already have been served, the former subsection is not repealed. Rather, to avoid any possible argument that there is no authority to continue the eligibility of an investment that was held by a life insurer on December 31, 1963, as an eligible investment under former § 88(1), this provision is transferred to the Session Laws.
The only changes are in style.

SECTION 8. AND BE IT FURTHER ENACTED, That Section(s) 490-O of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

HEALTH INSURANCE - LIMITED BENEFITS POLICIES

[490-O.]1.

(a) (1) In this section "limited benefits policy" means a health insurance contract or policy that provides benefits under the provisions of this section.

(2) "Mandated health insurance benefit" has the meaning stated in [§ 490M(a)(2) of this subtitle] § 15-1301(C) OF THE INSURANCE ARTICLE.

(3) "Nondiscrimination provision" has the meaning stated in [§ 490M(a)(3) of this subtitle] § 15-1301(D) OF THE INSURANCE ARTICLE.

(4) "Emergency services" means those health services which are provided in hospital emergency facilities after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to result in:

(i) Placing health in jeopardy;

(ii) Serious impairment to bodily functions;

(iii) Serious dysfunction of any bodily organ or part; or

(iv) Development or continuance of severe pain.

(b) (1) Until June 30, 1994, a limited benefits policy may be offered:

(i) On an individual basis, provided the individual:

1. Has not been covered by any health insurance plan, contract, or policy for the 12-month period preceding the date of application; and

2. Is not eligible for coverage under Medicare, 42 U.S.C. § 1395 et seq.; and

(ii) On a group basis to an employer, provided that the employer:

1. Has not provided any group health insurance plan, contract, or policy for the 24-month period preceding the date of application, or, if the employer has existed for less than 12 months, from the date the employer commenced its business; and

2. Employs at least 2 and no more than 25 full-time employees.

(2) A limited benefits policy may not be offered to an employer that alters its organizational structure or corporate form for the purpose of qualifying for a limited benefits policy.

(3) The provisions of [§ 233 of this article] TITLE 27, SUBTITLE 4 OF THE INSURANCE ARTICLE shall apply to a limited benefits policy and a violation of paragraph (2) of this subsection by an employer shall be considered a violation of [§ 233 of this article] TITLE 27, SUBTITLE 4 OF THE INSURANCE ARTICLE.

(c) (1) A limited benefits policy shall provide:

(i) Hospitalization coverage as provided in either paragraph (2)(i) or (ii) of this subsection;

(ii) 10 office visits with a licensed health care provider per insured per year for the diagnosis and treatment of any illness or injury, including reasonable coverage of medically necessary laboratory and diagnostic procedures and outpatient surgery;

(iii) Reasonable coverage of prenatal care, including:

1. A minimum of 1 prenatal office visit per month during the first 2 trimesters of pregnancy, 2 office visits per month during the 7th and 8th months of pregnancy, and 1 office visit per week during the 9th month and until term; and

2. All necessary and appropriate screening, physical examination, laboratory and diagnostic procedures, and prenatal counseling that the licensed health care provider determines are necessary;

(iv) Reasonable coverage of obstetrical care, including services by a licensed health care provider, delivery room, post partum care, and other medically necessary hospital services;

(v) Reasonable coverage of medically necessary emergency services; and

(vi) Newborn child care from birth, as provided under [§ 438A of this article] § 15-401 OF THE INSURANCE ARTICLE.

(2) An insurer or nonprofit health service plan shall offer to the individual or group the following options for inpatient hospitalization coverage:

(i) The first 10 days of inpatient hospital and professional services coverage per year, whether for mental or physical illness; or

(ii) The first 10 days of inpatient hospital and professional services coverage per year, limited to physical illness only.

(3) Benefits under paragraph (1)(i) and (ii) of this subsection shall include coverage for outpatient surgical procedures provided in a hospital or a freestanding ambulatory surgical facility.

(4) Benefits under paragraph (1)(ii) of this subsection shall include:

(i) Coverage for the diagnosis and treatment of acute mental conditions on an outpatient basis; and

(ii) Preventive services.

(5) With the approval of the INSURANCE Commissioner a limited benefits policy may provide benefits in addition to those required under this subsection.

(d) (1) A limited benefits policy:

(i) Shall contain an exclusion for services that are not medically necessary or are not covered preventive health services; and

(ii) Subject to the approval of the INSURANCE Commissioner, may include other managed care provisions to control costs, including:

1. Utilization review by the insurer or nonprofit health service plan;

2. Second surgical opinions;

3. A procedure for preauthorization of a medical service the costs of which are anticipated to exceed a minimum threshold amount; and

4. A panel of preferred providers to provide services at specified levels of reimbursement.

(2) Any agreement between a nonprofit health services plan or insurer and a panel under paragraph (1)(ii)4 of this subsection shall contain a provision that a policyholder or subscriber is not obligated to pay for a medical service rendered that is determined not to be medically necessary.

(3) Subject to the approval of the INSURANCE Commissioner, a limited benefits policy may include reasonable deductibles, copayment provisions, preexisting condition limitations of 10 months or less, and medical underwriting as provided under [this article] THE INSURANCE ARTICLE.

(e) (1) Prior to issuing a limited benefits policy, a nonprofit health service plan or insurer shall provide to a prospective policyholder a written statement that, at a minimum, discloses:

(i) Those mandated health insurance benefits and nondiscrimination provisions not covered by the policy;

(ii) The managed care and cost control features of the policy, along with all appropriate mailing addresses and telephone numbers to be utilized in seeking information or authorization;

(iii) That a lower cost health insurance policy may be available from another insurer or from a health maintenance organization, and that the prospective policyholder may contact the Maryland Insurance Commissioner for additional information and assistance; and

(iv) The primary and preventive care features of the policy.

(2) A statement provided under paragraph (1) of this subsection shall be in clear and understandable language.

(f) (1) Prior to issuing a limited benefits policy, a nonprofit health service plan or insurer shall obtain from a prospective policyholder:

(i) As a condition of coverage, the information form required under subsection (i) of this section; and

(ii) A signed written statement that:

1. Certifies as to the eligibility for coverage under the policy;

2. Acknowledges that the disclosure statement required under subsection (e) of this section was provided, and that the extent of the coverage and the managed care and cost control features of the policy were explained and understood; and

3. Acknowledges that the prospective policyholder was offered, at the time of application for the policy, the opportunity to purchase coverage that included all applicable mandated health insurance benefits and nondiscrimination provisions otherwise required by law.

(2) The nonprofit health service plan or insurer shall provide to the prospective policyholder a copy of the statement required under paragraph (1) of this subsection, and the original of the statement shall be retained in the files of the insurer or nonprofit health service plan for the longer of:

(i) The period that the policy is in effect; or

(ii) 5 years.

(g) (1) Except as provided in this section, all provisions of [this article] THE INSURANCE ARTICLE shall apply to a limited benefits policy.

(2) Notwithstanding any other provision of [this article] THE INSURANCE ARTICLE, a limited benefits policy is not subject to any mandated health insurance benefit or nondiscrimination provision.

(h) (1) An individual or employer is eligible for coverage under a limited benefits policy for a maximum of 3 consecutive years.

(2) An insurer or nonprofit health service plan may not cancel a limited benefits policy except for nonpayment of premiums or failure to satisfy established participation requirements.

(3) (i) If an individual or employer has been covered under a limited benefits policy and has not been canceled under paragraph (2) of this subsection, the insurer or nonprofit health service plan providing the limited benefits policy shall offer a nonlimited benefits policy to the individual or employer, provided the individual or employer makes application within 3 months from the date coverage under the limited benefits policy ends.

(ii) The policy offered under subparagraph (i) of this paragraph shall be offered:

1. Without medical underwriting; and

2. Without preexisting condition limitations to the extent any preexisting condition limitations under the limited benefits policy have been satisfied.

(4) Three months prior to the termination of a limited benefits policy, an insurer or nonprofit health service plan shall provide to the policyholder and all beneficiaries a notice of the required offering under paragraph (3) of this subsection.

(i) (1) The INSURANCE Commissioner shall adopt regulations:

(i) Establishing a standard form to be completed by a limited benefits policyholder under subsection (f)(1)(i) that gathers demographic data on the policyholder and insureds under the policy;

(ii) Establishing a standard format for the submission to the INSURANCE Commissioner by an insurer or nonprofit health service plan of data concerning the utilization of benefits and claims information under limited benefits policies;

(iii) Establishing for limited benefits policies a minimum loss ratio and a limit on the number of age bands which may be applied; and

(iv) To enforce the provisions of this section.

(2) By July 1 of each calendar year, each insurer or nonprofit health service plan shall provide to the INSURANCE Commissioner the information required under paragraph (1) of this subsection in a format approved by the INSURANCE Commissioner.

(3) The INSURANCE Commissioner shall approve limited benefit policy rates and terms before the policy may be issued and shall ensure that rates charged bear a reasonable and fair relationship to the benefits provided.

REVISOR'S NOTE: This section formerly was Art. 48A, § 490-O.

%Former Art. 48A, § 490-O, which authorized and regulated the issuance of limited benefits policies, provided that such policies could be offered only until June 30, 1994 and with a maximum term of 3 years. Section 4 of Chapter 434 of the Acts of 1991 provided that the 3-year term of a limited benefits policy shall be extended for 2 years under certain circumstances, but not beyond July 1, 1996. Because of the limited duration of the provisions of former § 490-O, it is transferred to the Session Laws.

The only changes are in style.

SECTION 9. AND BE IT FURTHER ENACTED, That Section(s) 504(a)(2) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

INSURER INSOLVENCY EXISTING ON JANUARY 1, 1985

[504.] 1.

[(a) (2)] All provisions of [this subtitle] TITLE 9, SUBTITLE 3 OF THE INSURANCE ARTICLE shall apply to any insurer insolvency, including surety, existing as of January 1, 1985.

REVISOR'S NOTE: This section formerly was Art. 48A, § 504(a)(2).

%Former Art. 48A, § 504(a)(2) provided that the provisions of Title 9, Subtitle 3 of the Insurance Article, which covers the Property and Casualty Insurance Guaranty Corporation, apply to any insurer insolvency existing as of January 1, 1985. Because of the limited and diminishing applicability of this provision, it is transferred to the Session Laws.

SECTION 10. AND BE IT FURTHER ENACTED, That Section(s) 552(a), (b), and (c) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

[552.] 1.

(a) Prior to the expiration of 15 days from June 1, 1975, the State Board of Physician Quality Assurance shall certify to the State Treasurer a list of all licensed physicians as shown in the records of the State Board of Physician Quality Assurance as of June 1, 1975.

(b) A special one-time tax for the privilege of practicing medicine in Maryland is levied on licensed physicians listed by the State Treasurer in accordance with subsection (a) in the amount of $300 per licensed physician, to be levied, assessed, and collected by the State Treasurer. The tax does not apply to any licensed physician who submits a statement, sworn to under penalties of perjury, stating that he has permanently terminated the active practice of medicine in the State of Maryland or that he is a physician serving in the employment of the federal government or any agency thereof and

does not otherwise practice medicine in the State of Maryland or to any licensed physician who submits a statement, sworn to under penalties of perjury, stating that he is practicing medicine as a volunteer for no remuneration at a clinic not operated for profit and stating that he is not otherwise engaged in the private practice of medicine in the State of Maryland or to any resident student physician whose services are not billed separately. The statement shall be in form established by the State Treasurer.

(c) The legislature appropriates and dedicates the proceeds of the tax provided by [this subtitle] TITLE 24, SUBTITLE 2 OF THE INSURANCE ARTICLE as the initial policyholders' surplus of the [Society] MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND. After retaining an amount to pay the cost of collection the Treasurer and Comptroller shall promptly pay over the proceeds of the tax to the Society.

REVISOR'S NOTE: This section formerly was Art. 48A, 552(a), (b), and (c).

%Former Art. 48A, § 552(a), (b), and (c) required the State Board of Physician Quality Assurance to certify a list of all licensed physicians as of June 1, 1975, levied a special one-time tax of $300 for the privilege of practicing medicine in the State, established exceptions to the payment of the tax, dedicated the proceeds of the tax, and required the Treasurer and Comptroller to pay over the proceeds of the tax to the Society. These provisions are transferred to the Session Laws because of their limited and diminishing applicability. The provisions are not obsolete at this time because a physician may be entitled to credit against liability for a membership fee paid under these provisions. See § 24-208(b) of the Insurance Article.

The only changes are in style.

SECTION 11. AND BE IT FURTHER ENACTED, That Section(s) 570(a), (b), (c), and (d) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

LEGAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

[570.] 1.

(a) Within 30 days after the date the [Society] LEGAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND is incorporated, the Clerk of the Court of Appeals of Maryland shall certify to the State Treasurer a list of all attorneys admitted to practice law in the State as shown in the records of the Clients' Security Trust Fund, as provided for in Article 10, § 43 of the Code on the date of the Society's incorporation.

(b) A special one-time tax for the privilege of practicing law in the State is levied on attorneys listed by the Treasurer in accordance with subsection (a) of this section in the amount of $150 per attorney, to be levied and assessed within 30 days of receipt of the certified list of attorneys. The tax shall be collected by the Treasurer within 60 days after receipt of the certified list of attorneys.

(c) If the tax imposed by this section is not paid within 60 days from the date the tax is levied and assessed, the attorney who is liable for its payment shall pay an

additional tax as a penalty. The penalty may not exceed 10 percent of the tax due, plus interest at the rate determined under § 13-604 of the Tax - General Article for each month the tax remains unpaid. Interest may not be assessed on the tax which is due as a penalty. If any attorney fails to pay the tax due under this section, on or before the date fixed for its payment, the full amount of all the tax due the State, together with any interest, penalty, or addition to the tax, shall be a lien in favor of the State upon all property and all rights to property, real or personal, belonging to the person in accordance with Title 13, Subtitle 8, Part II of the Tax - General Article.

(d) (1) The General Assembly of Maryland dedicates the proceeds of the tax provided by this section as the initial policyholders' surplus of the Society.

(2) After retaining an amount to pay the cost of collection, the Treasurer and Comptroller shall pay over the proceeds of the tax to the Society within 30 days.

REVISOR'S NOTE: This section formerly was Art. 48A, § 570(a), (b), (c), and (d).
%Former Art. 48A, § 570(a), (b), (c), and (d) required the Clerk of the Court of Appeals to certify a list of all attorneys admitted to practice law in the State, levied a special one-time tax of $150 for the privilege of practicing law in the State, established penalties for failure to pay the tax, dedicated the proceeds of the tax, and required the Treasurer and Comptroller to pay over the proceeds of the tax to the Society within 30 days. These provisions are transferred to the Session Laws because of their limited and diminishing applicability. The provisions are not obsolete at this time because a lawyer could still be subject to the penalties imposed for not paying the tax and because the lawyer may be entitled to credit against liability for a membership fee. See § 24-108(c)(2) of the Insurance Article.
The only changes are in style.

[573.] 2.

In applying the applicable provisions of [this article] THE INSURANCE ARTICLE dealing with rates and rate filings, the Commissioner shall permit an initial premium not in excess of 130 percent of the rate that would otherwise be applicable if the terms of the rate filing are such that any portion of the collected premiums that are ultimately determined as having been in excess of the Society's costs shall be returned on a nondiscriminatory basis to the policyholders of the Society.

REVISOR'S NOTE: This section formerly was Art. 48A, § 573.
%Former Art. 48A, § 573 provided for an initial premium for policyholders of the Society. This provision is not retained in the Code because it is apparently obsolete. However, it is transferred to the Session Laws to avoid any inadvertent substantive effect that its repeal might have.
The only changes are in style.

SECTION 12. AND BE IT FURTHER ENACTED, That Section(s) 689(b)(3) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

APPLICABILITY OF TESTING PROCEDURES TO THIRD PARTY ADMINISTRATORS

[689.] 1.

[(b) (3)] The testing procedures adopted under [this section] § 8-304(B) OF THE INSURANCE ARTICLE shall apply only to applicants whose initial registration is on or after January 1, 1994.

REVISOR'S NOTE: This section formerly was Art. 48A, § 689(b)(3).
%Former Art. 48A, § 689(b)(3) provided that the testing procedures adopted under that former section apply only to applicants whose initial registration is on or before January 1, 1994. This provision is transferred to the Session Laws because it is now of limited application.
The only changes are in style.

SECTION 13. AND BE IT FURTHER ENACTED, That Section(s) 702(b)(1)(i) and (ii) of Article 48A - Insurance Code of the Annotated Code of Maryland be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

PREMIUM RATES FOR HEALTH BENEFIT PLANS

[702.] 1.

[(b) (1)] Based on the adjustments allowed under [subsection (a)(2) of this section] § 15-1205(A)(2) OF THE INSURANCE ARTICLE, a carrier may charge a rate that is:

[(i)] (1) 50% above or below the community rate for any health benefit plan issued, delivered, or renewed between July 1, 1994 and June 30, 1995; AND

[(ii)] (2) 40% above or below the community rate for any health benefit plan issued, delivered, or renewed between July 1, 1995 and June 30, 1996[; and].

REVISOR'S NOTE: This section formerly was Art. 48A, § 702(b)(1)(i) and (ii).
%Former Art. 48A, § 702(b)(1)(i) and (ii) phased in, from July 1, 1994 through June 30, 1996, the limits on the rate a carrier may charge for health benefit plans under the Maryland Health Insurance Reform Act. These provisions are apparently obsolete. However, they are transferred to the Session Laws to avoid any inadvertent substantive effect their repeal might have.
The only changes are in style.

SECTION 14. AND BE IT FURTHER ENACTED, That Section(s) 10-118(a)(3) of Article - Insurance of the Annotated Code of Maryland, as enacted by Chapter 271, § 2 of the Acts of the General Assembly of 1996, be repealed and reenacted, with amendments, and transferred to the Session Laws, to read as follows:

AGENTS - APPOINTMENTS

[10-118.] 1.

[(a) (3)] The appointment and appointment fee provisions of [this subsection] § 10-118(A) OF THE INSURANCE ARTICLE do not apply to agents with an appointment from an insurer on June 30, 1985.

SECTION 15. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Contingent Provisions of Maryland Health Insurance Reform Act.

1. Definitions.

(a) In general.

In this subheading the following words have the meanings indicated.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(a) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

(b) Board.

"Board" means the Board of Directors of the Pool established under § 13 of this subheading.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(c) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined term: "Pool" § 1

(c)
Carrier.

"Carrier" means:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan that is licensed to operate in the State;

(3) a health maintenance organization that is licensed to operate in the State; or

(4) any other person or organization that provides health benefit plans subject to State insurance regulation.

REVISOR'S NOTE: This subsection is new language derived without substantive change from former Art. 48A, § 698(d) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In item (1) of this subsection, the defined term "authorized insurer" is

substituted for the former reference to an "insurer that holds a certificate of authority in the State" for brevity and consistency with the terminology used throughout the Insurance Article.

Defined terms: "Certificate of authority" IN § 1-101
"Health benefit plan" § 1
"Health insurance" IN § 1-101
"Insurance" IN § 1-101
"Insurer" IN § 1-101
"Person" IN § 1-101

(d) Commission.

"Commission" means the Maryland Health Care Access and Cost Commission established under Title 19, Subtitle 15 of the Health - General Article.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(e) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
No changes are made.

(e) Eligible individual.

"Eligible individual" means an individual who is eligible to enroll in a health benefit plan in the State in accordance with § 2 of this subheading.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(g) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined term: "Health benefit plan" § 1

(f)
Employer.

"Employer" means a person that:

(1) is actively engaged in business; and

(2) has had on at least 50% of its working days during the preceding calendar year a majority of its employees employed in the State, where in determining the number of employees of employer companies that are affiliated companies or that are eligible to file a consolidated federal income tax return shall be considered one employer.

REVISOR'S NOTE: This subsection is new language derived without substantive change from former Art. 48A, § 698(p) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In the introductory language of this subsection, the former reference to "person, sole proprietor, firm, corporation, partnership, or association" is deleted as unnecessary.

In item (2) of this subsection, the reference to the number of "employees of an employer" is substituted for the former reference to the number of "eligible employees" for clarity and because the term "eligible employee" is not a defined term for the provisions of this subheading that are effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994.

Defined term: "Person" IN § 1-101

(g)

Health benefit plan.

(1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that is issued through a multiple employer trust or association located in this State or another state and that covers residents of this State.

(3) "Health benefit plan" does not include:

(i) accident-only insurance;

(ii) fixed indemnity insurance;

(iii) credit health insurance;

(iv) Medicare supplement policies;

(v) long-term care insurance;

(vi) disability income insurance;

(vii) coverage issued as a supplement to liability insurance;

(viii) workers' compensation or similar insurance;

(ix) disease-specific insurance;

(x) automobile medical payment insurance;

(xi) dental insurance; or

(xii) vision insurance.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(h) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

The only changes are in style.

The Insurance Article Review Committee notes, for consideration by the General Assembly, that Chapter 501, Acts of 1995 amended the definition of

"health benefit plan" (that was not subject to any contingencies) to exclude "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policies". No comparable change was made to the definition of "health benefit plan" that is subject to the contingencies contained in Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994.

Defined terms: "Health insurance" IN § 1-101
"Insurance" IN § 1-101
"Policy" IN § 1-101
"State" IN § 1-101

(h) Late enrollee.

"Late enrollee" means an individual who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan.

REVISOR'S NOTE: This subsection is new language derived without substantive change from former Art. 48A, § 698(i)(1) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The former phrase "under this subtitle", which modified the defined term "health benefit plan", is deleted as unnecessary because the term is defined for this subheading.
Former Art. 48A, § 698(i)(2), which specified who may not be considered a late enrollee, is revised as a substantive provision in § 6(b)(1) of this subheading.

Defined term: "Health benefit plan" § 1

(i)
Pool.

"Pool" means the Maryland Health Reinsurance Pool established under this subheading.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(k) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined term: "Reinsurance" IN § 1-101

(j)
Preexisting condition.

"Preexisting condition" means:

(1) a condition existing during a specified period immediately preceding the effective date of coverage that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(l) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined term: "Person" IN § 1-101

(k)
Preexisting condition provision.

"Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(m) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
No changes are made.

Defined terms: "Health benefit plan" § 1
"Preexisting condition" § 1

(l) Reinsuring carrier.

"Reinsuring carrier" means a carrier that participates in the Pool.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(n) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined terms: "Carrier" § 1
"Pool" § 1

(m) Risk-assuming carrier.

"Risk-assuming carrier" means a carrier that does not participate in the Pool.

REVISOR'S NOTE: This subsection formerly was Art. 48A, § 698(o) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The only changes are in style.

Defined terms: "Carrier" § 1
"Pool" § 1

(n) Standard Plan.

"Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15-1207 of the Insurance Article and Title 19, Subtitle 15 of the Health - General Article.

REVISOR'S NOTE: This subsection is new language derived without substantive change from former Art. 48A, § 698(f) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The term "Standard Plan" is substituted for the former defined term "Comprehensive Standard Health Benefit Plan" for brevity.
Defined term: "Commission" IN § 15-1201

REVISOR'S NOTE TO SECTION:

Former Art. 48A, § 698(j) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994) is deleted because it is not used as a defined term in the sections that are effective subject to the contingencies in Ch. 9, Acts of 1993. The substance of the term has been incorporated into the revision of § 15-1207 of the Insurance Article, although that section is not subject to the contingencies provided in Ch. 9, Acts of 1993.

2. Enrollment process.

(a) In general.

Each carrier shall establish an enrollment process in accordance with this section.

(b) Initial enrollment period.

Beginning on the 60th day after an individual establishes residency in the State, the individual shall be offered, for a 30-day period, an opportunity to enroll in a health benefit plan.

(c) Annual and special enrollment periods.

Each carrier shall:

(1) establish an annual period, of not less than 30 days, during which an individual may enroll in a health benefit plan or change the health benefit plan in which the individual is enrolled; and

(2) provide for a special enrollment period in which an individual is allowed to change the individual or family basis of coverage or the health benefit plan in which the individual is enrolled if the individual:

(i) through marriage, divorce, birth or adoption of a child, or similar circumstances, experiences a change in family composition; or

(ii) experiences a change in employment status including a significant change in the terms and conditions of employment.

(d) Filing of enrollment period plans.

Plans for open enrollment and special enrollment periods shall be filed with the Commissioner.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 702A (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1

3. Requirements and limitations for carriers.

(a) In general.

In addition to any other requirement under the Insurance Article, a carrier that offers a health benefit plan in the State shall:

(1) have demonstrated the capacity to administer the health benefit plan, including adequate numbers and types of administrative personnel;

(2) have a satisfactory grievance procedure and ability to respond to enrollees' calls, questions, and complaints;

(3) provide, in the case of individuals covered under more than one health benefit plan, for coordination of coverage under all of those health benefit plans in an equitable manner; and

(4) design policies to help ensure adequate access to providers of health care.

(b) Standard Plan required.

A person may not offer a health benefit plan in the State unless the person offers at least the Standard Plan.

(c) Less than minimum coverage prohibited.

A carrier may not offer a health benefit plan that has fewer benefits than those in the Standard Plan.

(d) Optional additional coverage.

A carrier may offer benefits in addition to those in the Standard Plan if the additional benefits:

(1) are offered and priced separately from benefits specified in accordance with § 15-1207 of the Insurance Article; and

(2) do not have the effect of duplicating any of those benefits.

(e) Point of service delivery system.

Notwithstanding subsection (b) of this section, a health maintenance organization may provide a point of service delivery system as an additional benefit through another carrier regardless of whether the other carrier also offers the Standard Plan.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 699 (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994 and Ch. 501, Acts of 1995).

In subsection (a)(4) of this section, the former references to "enrollees" and "insureds" are deleted as surplusage.

In subsection (b) of this section, the references to a "person" are substituted for the former references to a "carrier" for conformity with the comparable provisions of the Insurance Article that are not subject to contingencies. No substantive change is intended.

Also in subsection (b) of this section, the former reference to the plan "specified by the Commission under § 700 of this subtitle" is deleted as unnecessary in light of the defined term "Standard Plan".

In the introductory language of subsection (d) of this section, the reference to a "carrier" is added to allow the use of the active voice and to allow a construction that is parallel to the construction used in subsections (a) and (c) of this section.

Defined terms: "Carrier" § 1
"Health benefit plan" § 1
"Person" IN § 1-101
"Policy" IN § 1-101
"Standard Plan" § 1

4. Premium rates for health benefit plans.

(a) Community rate.

(1) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to health status or occupation or any other factor not specifically authorized under this subsection.

(2) A carrier may adjust the community rate only for:

(i) age; and

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; and

4. Eastern and Southern Maryland.

(3) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

(b) Consistent application of risk adjustment factors.

A carrier shall apply all risk adjustment factors under subsection (a) of this section consistently with respect to all health benefit plans that are issued, delivered, or renewed in the State.

(c) Allowable rates.

Based on the adjustments allowed under subsection (a)(2) of this section, a carrier may charge a rate that is 16% above or below the community rate.

(d) Basis of rating methods and practices.

A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, §§ 702(a) and (b)(4) and 703(a) and (d)(1) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

In subsection (a)(1) of this section, the reference to "all risks" is substituted for the former reference to "the entire pool of risks" to avoid confusion with the defined term "Pool".

In subsection (c) of this section, the former reference to "all health benefit plans issued, delivered, or renewed after July 1, 1997" is deleted as obsolete since that date has passed. Similarly, former Art. 48A, § 702(b)(1) through (3), which phased in, from July 1, 1994 through June 30, 1997, the limits on the rate a carrier may charge, is deleted as obsolete.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1

5. Miscellaneous operations requirements for carriers.

(a) Transfers.

(1) A carrier may not arbitrarily transfer a group or individual involuntarily into or out of a health benefit plan.

(2) A carrier may not offer to transfer a group or individual into or out of a health benefit plan unless the offer to transfer is made to all individuals or groups with similar risk adjustment factors.

(b) Disclosures in solicitation and sales materials.

A carrier shall make a reasonable disclosure in its solicitation and sales materials of:

(1) the provisions that relate to the carrier's right to change premium rates, including any factors that may affect the changes in premium rates;

(2) the provisions that relate to renewability of policies and contracts;

(3) the provisions that relate to preexisting conditions; and

(4) the provisions of § 7 of this subheading that require an employer to make dependent coverage available to employees but do not require the employer to make a contribution to the premium payments for that dependent coverage.

(c) Minimum participation requirements.

Subject to the approval of the Commissioner and as provided under § 7(c) of this subheading, a carrier may impose reasonable minimum participation requirements.

(d) Actuarial certifications.

(1) On or before March 15 of each year, each carrier shall file an actuarial certification with the Commissioner.

(2) The actuarial certification shall be written in a form that the Commissioner approves, by a member of the American Academy of Actuaries or another person acceptable to the Commissioner and shall state that the carrier is in compliance with this subheading and has followed the rating practices imposed under § 4 of this subheading.

(3) The actuarial certification shall be based on an examination that includes a review of appropriate records and actuarial assumptions and methods used by the carrier.

(e) Records.

(1) To indicate compliance with subsections (b) and (c) of this section and § 4(d) of this subheading, a carrier shall maintain information and documentation that is satisfactory to the Commissioner.

(2) A carrier shall:

(i) retain all information and documentation required under this subheading at its principal place of business for a period of 5 years; and

(ii) make the information and documentation available to the Commissioner on request.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, §§ 698(b) and 703(b), (c), (d)(2), (e), (f), and (g) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (d) of this section, the former definition of "actuarial certification" is consolidated into the substantive provision because the defined term was used only once under former law.
In subsection (e)(2)(i) of this section, the reference to "information and documentation" is substituted for the former reference to "documents and certifications" for consistency within this subsection.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Employer" § 1

"Health benefit plan" § 1
"Person" IN § 1-101
"Policy" IN § 1-101
"Preexisting condition provision" § 1
"Premium" IN § 1-101

6. Coverage of preexisting conditions.

(a) Limitation prohibited.

(1) A carrier may not limit coverage under a health benefit plan for a preexisting condition.

(2) An exclusion of coverage for preexisting conditions may not be applied to health care services furnished for pregnancy or newborns.

(b) Exception for late enrollee.

(1) This subsection does not apply to a late enrollee if:

(i) the individual requests enrollment in accordance with § 2 of this subheading;

(ii) a court has ordered coverage to be provided for a spouse or minor child under a covered individual's health benefit plan; or

(iii) a request for enrollment is made within 30 days after the individual's marriage or the birth or adoption of a child.

(2) Notwithstanding subsection (a) of this section, a late enrollee may be subject to a 12-month preexisting condition provision.

(c) Waiting period.

(1) A health benefit plan that does not use a preexisting condition provision may impose on enrollees a waiting period not to exceed 30 days before the coverage under the health benefit plan is effective.

(2) During the waiting period, the health benefit plan is not required to provide health care services or benefits and a premium may not be charged to the enrollee.

(d) Deductibles and cost-sharing.

For a period not to exceed 6 months after the date an individual becomes an employee, a health benefit plan may require deductibles and cost-sharing for benefits for a preexisting condition of the employee in amounts not exceeding 1.5 times the amount of the standard deductibles and cost-sharing of other employees if:

(1) the employee was not previously covered by public or private plan of health insurance or another health benefit arrangement; and

(2) the employee was not previously employed by that employer.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, §§ 701(a)(3) and (4), (b), (c), and (d) and 698(i)(2) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

In subsection (a)(1) of this section, the former effective date "January 1, 1995" is deleted as unnecessary since that date has passed.

The Insurance Article Review Committee notes, for consideration by the General Assembly, that Chapter 258, Acts of 1994 amended former Art. 48A, § 701(b) to allow a late enrollee to be subject to "a waiting period until the next open enrollment period not to exceed a 12-month period". A similar amendment was not made to the version of § 701(b) that is subject to the contingencies contained in Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994. In addition there are differences between the contingent and noncontingent versions of former Art. 48A, § 701(c) (revised as § 6(c) of this subheading and as § 15-1208(c) of the Insurance Article).

Former Art. 48A, § 701(a)(1) and (2), which authorized carriers until December 31, 1994 to limit coverage under a preexisting condition provision, subject to specified limitations, is deleted as obsolete.

Defined terms: "Carrier" § 1
"Employer" § 1
"Health benefit plan" § 1
"Health insurance" IN § 1-101
"Late enrollee" § 1
"Preexisting condition" § 1
"Preexisting condition provision" § 1
"Premium" IN § 1-101

7. Issuance of health benefit plans.

(a) Issuance required.

A carrier shall issue its health benefit plans to each group or individual that meets the requirements of this section.

(b) Requirements for employers.

(1) Nothing in this subsection requires an employer or group to contribute to the premium payments for coverage of a dependent of an employee.

(2) To be covered under a health benefit plan offered by a carrier, a group or individual shall:

(i) elect to be covered;

(ii) agree to pay the premiums;

(iii) agree to offer coverage to any dependent of an employee when coverage is sought by the employee, in accordance with provisions governing late enrollees and any other provisions of this subheading that apply to coverage;

(iv) agree to collect payments for premiums through payroll deductions for coverage of employees and dependents and transmit those payments to the carrier; and

(v) satisfy the other reasonable provisions of the health benefit plan as approved by the Commissioner.

(c) Uniform application of requirements by carrier.

(1) In determining whether a group satisfies the requirements of this section, a carrier shall apply its requirements uniformly among all groups with the same number of members who apply for or receive coverage from the carrier, including a requirement that a minimum percentage of the group participate in the health benefit plan.

(2) A carrier may vary application of minimum participation of group members only by the size of the group.

(d) Required contributions to premium payments prohibited.

A carrier may not require an employer to contribute to payment of premiums for a health benefit plan.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 704(a)(1) through (5)(effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (b)(2)(ii) of this section, the former reference to "required" premium payments is deleted as implicit since premiums are required to be paid under a contract for health benefits.
In subsection (b)(2)(iii) of this section, the reference to "provisions governing late enrollees and any other provisions of this subheading that apply to coverage" is substituted for the former reference to "any late enrollee or other provisions of this subtitle" for clarity.
Subsection (c)(1) of this section is revised to clarify that the only requirements a carrier may impose on a group are the requirements in this section. This revision is consistent with subsection (b) of this section, which guarantees issuance of a health benefit plan to groups or individuals who meet those requirements.
In subsection (d) of this section, the prohibition against requiring "an employer to contribute to payment of premiums for a health benefit plan" is substituted for the former prohibition against "minimum employer contributions" to clarify the limitation placed on carriers with respect to employer contributions.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Employer" § 1
"Health benefit plan" § 1
"Late enrollee" § 1

"Premium" IN § 1-101

8. Offering of coverage by carriers.

(a) In general.

A carrier that offers coverage to a group shall offer coverage to all of its members.

(b) Health maintenance organizations.

(1) A health maintenance organization need not offer coverage:

(i) to an individual or group that is outside of the health maintenance organization's approved service areas;

(ii) to a member of a group who resides outside of the health maintenance organization's approved service areas; or

(iii) within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity in its network of providers to deliver service adequately because of obligations to existing group contract holders and enrollees.

(2) A health maintenance organization that does not offer coverage under paragraph (1)(iii) of this subsection may not offer coverage in the applicable area to any individuals or groups until the later of:

(i) 180 days after a refusal to do so; or

(ii) the date on which the health maintenance organization notifies the Commissioner that it has regained capacity to deliver services to individuals or groups in that area.

(c) Financial impairment.

A carrier may not be required to offer coverage under §§ 7 and 11 of this subheading for as long as the Commissioner finds that the coverage would place the carrier in a financially impaired condition.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 704(b) through (d) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (b)(1)(iii) of this section, the former phrase "within the area", which modified "capacity", is deleted as unnecessary in light of the use of the phrase "within an area" at the beginning of that item.
In subsection (b)(2)(ii) of this section, the reference to the "area" in which a health maintenance organization has the "capacity to deliver services to individuals or groups" is added for clarity.
Also in subsection (b)(2)(ii) of this section, the specific reference to a "health maintenance organization" is substituted for the former general reference to a "carrier" for consistency within that subsection.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101

9. Approval of proposed health benefit plans.

(a) Filing required.

To sell health benefit plans to individuals or groups in the State, a carrier shall file its proposed health benefit plans with the Commissioner on or before the date designated by the Commissioner.

(b) Deemed approval.

Unless the Commissioner previously has disapproved a health benefit plan, it is deemed approved 60 days after filing with the Commissioner.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 704(e) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1

10. Renewal of health benefit plans.

(a) In general.

A carrier shall renew health benefit plans, except in any of the following cases:

(1) nonpayment of premiums;

(2) fraud or misrepresentation of an enrollee or representative of an enrollee;

(3) repeated misuse of a provider network provision including unreasonable refusal of the enrollee to follow a prescribed course of treatment, abusive overutilization by an enrollee, or violation of reasonable policies of a carrier; or

(4) the carrier elects to terminate all health benefit plans in the State.

(b) Notice of nonrenewal required; new business prohibited.

(1) A carrier that elects not to renew health benefit plans shall:

(i) provide advance notice of its decision under this paragraph to the Commissioner; and

(ii) provide notice of the decision to enrollees at least 120 days prior to the nonrenewal of any health benefit plan by the carrier.

(2) The carrier may not write new business in the State until the earlier of:

(i) 5 years after the date of notice to the Commissioner; or

(ii) when the Commissioner invites the carrier to renew participation.

(c) Election of carrier to nonrenew all plans.

When a carrier elects not to renew all health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected small employers and the insurance regulatory authority of each state in which an eligible employee or dependent resides at least 180 days before the effective date of nonrenewal;

(2) shall give notice to the Commissioner at least 30 working days before giving the notice specified in item (1) of this subsection; and

(3) may not write new business for small employers in the State for a period of 5 years beginning on the date of notice to the Commissioner.

(d) Notice to employees.

Within 7 days after cancellation or nonrenewal of a health benefit plan, the carrier shall send to each enrolled employee written notice of its action and the conversion rights available to each enrolled employee under § 15-412 of the Insurance Article.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 705 (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (a)(1) of this section, the former reference to "required" premiums is deleted as implicit since premiums are required to be paid under a contract for health benefits.
The Insurance Article Review Committee notes, for consideration by the General Assembly, that it is not clear whether subsection (b) of this section applies to the nonrenewal of all of a carrier's health benefit plans or to the nonrenewal of a particular health benefit plan. There is also some duplication and possible conflict between subsections (b) and (c) of this section. In addition, in subsection (c) of this section, the terms "eligible employee" and "small employer" are used even though they are not defined in these sections that are effective subject to the contingencies in Ch. 9, Acts of 1993. The use of the defined terms "eligible individual" and "employer" would seem to better reflect the intent of the General Assembly.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Employer" § 1
"Health benefit plan" § 1
"Insurance" IN § 1-101
"Premium" IN § 1-101
"State" IN § 1-101

11. Benefits additional to Standard Plan.

Each benefit added to the Standard Plan by a rider shall be subject to all of the provisions of this subheading applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal;

(3) adjusted community rating;

(4) the prohibition on preexisting condition limitations; and

(5) any other provisions the Commissioner determines are necessary to achieve the purposes of this subheading.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 704(a)(6) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994). In the introductory language of this section, the reference to "all of the provisions of this subheading applicable to" the Standard Plan is substituted for the former reference to "the same requirements as" the Standard Plan for clarity.

Defined terms: "Commissioner" IN § 1-101
"Preexisting condition" § 1
"Standard Plan" § 1

12. Election to become risk-assuming carrier or reinsuring carrier.

(a) Required.

(1) Each carrier shall elect to become either a risk-assuming carrier or reinsuring carrier.

(2) The notification of election to become a risk-assuming carrier shall include an appropriate opinion by an independent qualified actuary that the risk-assuming carrier is able to assume and manage the risk of enrolling individuals or groups without the protection of the Pool.

(b) Duration of election; new carriers.

(1) The initial election under this section is binding for 3 years.

(2) After the initial 3 years, and every 5 years thereafter, carriers shall again elect to be either a risk-assuming or reinsuring carrier.

(3) Each subsequent election is binding for 5 years.

(4) The Commissioner may allow a new carrier to make an election under conditions established by the Commissioner.

(c) Change of election.

(1) The Commissioner may allow a carrier to change its election at any time for good cause shown.

(2) In determining whether to approve an application by a carrier to change its election, the Commissioner shall consider:

(i) the applicant's financial condition and the financial condition of any parent or guaranteeing corporation;

(ii) the applicant's history of assuming and managing risk;

(iii) the applicant's commitment to market fairly to all individuals or groups in the State or in the applicant's service area;

(iv) the applicant's ability to assume and manage the risk of enrolling individuals or groups without the protection of the Pool; and

(v) the effect of approval of the application on the financial viability of the Pool.

(3) While the Commissioner is considering an application under this subsection, the carrier may request a hearing as provided under Title 11, Subtitle 5 of the Insurance Article.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 706(a)(1) and (3), (b), (c), and (d) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (a)(2) of this section, the reference to the "notification of election to become a risk-assuming carrier" is substituted for the former references to the "notification of a risk-assuming carrier" for clarity.
In subsection (b)(1) and (3) of this section, the words "initial" and "subsequent", respectively, are added to modify "election" to distinguish between the first election to become a risk-assuming carrier and later ones.
In subsection (c)(3) of this section, the reference to the "Commissioner" considering an application is added for clarity.
Former Art. 48A, § 706(a)(2), which required an election to be submitted to the Commissioner by July 1, 1994, is deleted as obsolete.

Defined terms: "Carrier" § 1
"Commissioner" IN § 1-101
"Pool" § 1
"Reinsuring carrier" § 1
"Risk-assuming carrier" § 1

13. Maryland Health Reinsurance Pool.

(a) Establishment.

The Commissioner shall establish the Maryland Health Reinsurance Pool and shall notify all carriers approved to be health insurance carriers of steps taken to establish the Pool.

(b) Commencement of operations.

The Pool shall be operational and may reinsure claims in accordance with this subheading on or after July 1, 1994.

(c) Initial meetings of Board of Directors.

(1) By July 1, 1994, the Commissioner shall notify all carriers applying to sell health benefit plans to individuals or groups in the State of the time and place of the initial meeting of the Board.

(2) Until Board members are elected, the Commissioner shall convene the initial meeting and all subsequent meetings of the Board and shall administer its affairs.

(3) The initial organizational meeting shall take place by October 1, 1994.

(d) Membership of Board of Directors.

(1) The reinsuring carriers shall elect an initial Board of Directors to be composed of seven members.

(2) If the initial Board is not elected at the organizational meeting, the Commissioner shall appoint the initial Board within 60 days after the organizational meeting.

(3) To the extent possible, the Board shall include representation from at least one nonprofit health service plan, at least one commercial carrier, and at least one health maintenance organization.

(4) A carrier, including its affiliates, may not be represented by more than one member on the Board.

(5) The term of a member is 3 years except that the terms of initial members shall be staggered for periods of 1 to 3 years.

(6) At the end of a term, a member continues to serve until a successor is elected.

(7) Vacancies shall be filled by an election of the remaining Board members.

(8) A member who is elected after a term has begun serves only for the rest of the term and until a successor is elected.

(9) A member who serves two consecutive full 3-year terms may not be reelected for 3 years after the completion of those terms.

(e) Chairman.

The Board shall choose a chairman.

(f) Executive Director.

(1) The Board shall appoint an Executive Director, who shall be the chief administrative officer of the Pool.

(2) The Executive Director serves at the pleasure of the Board.

(3) Under the direction of the Board, the Executive Director shall perform any duty or function that the Board requires.

(g) Staff.

The Pool may employ a staff in accordance with the budget of the Pool.

(h) Plan of operation.

(1) Within 180 days after the election of the initial Board, the Board shall submit to the Commissioner a plan of operation to ensure the fair, reasonable, and financially sound administration of the Pool.

(2) If the Board fails to submit a plan of operation within 180 days after its election, the Commissioner, after notice and hearing, shall adopt a temporary plan of operation.

(3) The Commissioner may amend or rescind a plan of operation if the Commissioner finds that the Pool is not operating in a fair, reasonable, and financially sound manner.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 707(a) through (j) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (b) of this section, the reference to the reinsurance of claims "in accordance with this subheading" is substituted for the former reference to the reinsurance of claims "of eligible health benefit plans" for clarity. The applicable provisions of this subheading specify how claims are to be reinsured but they do not clearly specify which health benefit plans are "eligible" for reinsurance. See §§ 14 and 15 of this subheading.

Defined terms: "Board" § 1
"Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1
"Health insurance" IN § 1-101
"Pool" § 1
"Reinsurance" IN § 1-101
"Reinsuring carrier" § 1

14. Reinsurance.

(a) In general.

A reinsuring carrier may reinsure with the Pool as provided in this section.

(b) Minimum level of reinsurance.

At a minimum, the Pool shall reinsure up to the level of coverage specified under the Standard Plan.

(c) Timing of reinsurance of groups.

A reinsuring carrier may reinsure an entire group within 60 days of commencement of the group's coverage under a health benefit plan.

(d) Timing of reinsurance of individuals.

(1) A reinsuring carrier may reinsure a group member or dependent within 60 days after commencement of the group's coverage.

(2) A reinsuring carrier may reinsure a newly eligible group member or dependent within 60 days after commencement of coverage of the new member or dependent.

(e) Reimbursement of claims.

(1) The Pool may not reimburse a reinsuring carrier with respect to the claims of an individual until the reinsuring carrier has incurred claims for the individual of $5,000 in a calendar year for benefits covered by the Pool.

(2) After the initial $5,000 of incurred claims, the reinsuring carrier is responsible for 10% of the next $50,000 of incurred claims during the calendar year, and the Pool shall reinsure the remainder.

(3) The liability of a reinsuring carrier under this subsection may not exceed $10,000 in any 1 calendar year with respect to any individual.

(f) Adjustment of limitations.

(1) The Board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans in the State.

(2) Unless the Board proposes and the Commissioner approves a lower adjustment factor, the adjustment in paragraph (1) of this subsection may not be less than the annual change in the medical component of the "Consumer Price Index for all Urban Consumers" of the Department of Labor, Bureau of Labor Statistics.

(g) Termination of reinsurance.

A reinsuring carrier may terminate reinsurance on a plan anniversary for one or more of the individual members of a group.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 709(a) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

In subsections (c), (e)(1), (f)(1), and (g) of this section, the defined term "reinsuring carrier" is substituted for the former references to a "carrier" for consistency within this section.

In subsection (e)(2) of this section, the reference to the "Pool" is substituted for the former reference to the "program" because there is no program of reinsurance, only the "Pool".

Defined terms: "Board" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1
"Pool" § 1
"Reinsurance" IN § 1-101
"Reinsuring carrier" § 1
"Standard Plan" § 1

15. Premiums for reinsurance.

(a) In general.

(1) (i) As part of the plan of operation, the Board shall establish a methodology to determine premium rates to be charged by the Pool for reinsuring groups and individuals under this section and § 14 of this subheading.

(ii) The methodology shall provide for the development of base reinsurance premium rates that shall be multiplied by the factors set forth in paragraph (2) of this subsection to determine the premium rates for the Pool.

(iii) The Board shall establish the base reinsurance premium rates at levels that reasonably approximate gross premiums charged to groups by carriers for health benefit plans up to the level of coverage that the Board determines.

(2) Premiums for the Pool shall be as follows:

(i) an entire group may be reinsured for a rate that is 1.5 times the base reinsurance premium rate for the group established under this subsection; and

(ii) an individual may be reinsured for a rate that is 5 times the base reinsurance premium rate for the individual established under this subsection.

(3) (i) The Board periodically shall review the methodology established under paragraph (1) of this subsection, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the Pool.

(ii) The Board may propose changes to the methodology, subject to the approval of the Commissioner.

(b) Premiums charged to groups.

If a health benefit plan for a group is entirely or partially reinsured with the Pool, the premium charged to the group for any rating period for the coverage issued shall meet the requirements that relate to premium rates set forth in § 4 of this subheading.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 709(b) and (c) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
In subsection (a)(2)(ii) of this section, the former reference to a "group member" is deleted as included in the reference to an "individual".
In subsection (b) of this section, the reference to the "Pool" is substituted for the former reference to the "program" because there is no "program" of

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reinsurance, only the "Pool".

Defined terms: "Board" § 1
"Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1
"Pool" § 1
"Premium" IN § 1-101
"Reinsurance" IN § 1-101

16. Assessments to recoup losses by Pool.

(a) Determination and reporting of net loss.

On or before the last day of February of each year, the Board shall determine and report to the Commissioner the net loss of the Pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Recoupment from reinsuring carriers.

Any net loss for the year shall be recouped by assessments imposed on reinsuring carriers.

(c) Assessment formula.

(1) As part of the plan of operation, the Board shall establish a formula to make assessments against reinsuring carriers.

(2) The assessment formula shall be based on:

(i) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery in the State by reinsuring carriers; and

(ii) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans that are delivered or issued for delivery during that calendar year in the State by reinsuring carriers.

(3) The assessment formula may not result in an assessment share for a reinsuring carrier that is less than 50% nor more than 150% of an amount that is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery in the State to total premiums earned by all reinsuring carriers in the preceding calendar year from health benefit plans that are delivered or issued for delivery in the State.

(4) As appropriate and with the approval of the Commissioner, the Board may change the assessment formula established in accordance with this subsection.

(5) The Board may provide for assessment shares attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.

(6) Subject to the approval of the Commissioner, the Board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations and that are federally qualified under the Health Maintenance Organization Act of 1973 to the extent that restrictions are placed on the health maintenance organizations that are not imposed on other carriers.

(7) Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the Board to justify the cost of collection may not be considered in determining assessments.

(d) Estimate of assessments needed.

(1) On or before the last day of February each year, the Board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the Pool in the previous calendar year.

(2) If the Board determines that the assessments needed to fund the losses incurred by the Pool in the previous calendar year will exceed 5% of the total premiums earned that year from health benefit plans that are delivered or issued for delivery in the State, the Board shall evaluate the operation of the Pool and report its findings to the Commissioner within 90 days after the end of the calendar year in which the losses were incurred.

(3) The evaluation required under paragraph (2) of this subsection shall include:

(i) any recommendations for changes to the plan of operation;

(ii) an estimate of future assessments;

(iii) the administrative costs of the Pool;

(iv) the appropriateness of the premiums charged;

(v) the level of insurer retention under the Pool; and

(vi) the costs of coverage for individuals and groups.

(4) If the Board fails to file the report with the Commissioner within 90 days after the end of the applicable calendar year, the Commissioner may evaluate the operations of the Pool and implement amendments to the plan of operation that the Commissioner considers necessary to reduce future losses and assessments.

(e) Excess of assessments over net losses.

If assessments exceed net losses of the Pool, the excess shall be held in an interest-bearing account and used by the Board to offset future losses, including reserves for incurred but not reported claims, or to reduce Pool premiums.

(f) Determination of assessment share.

The Board annually shall determine the assessment share of each reinsuring carrier based on annual statements and other reports that the Board considers necessary and that reinsuring carriers file with the Board.

(g) Penalty for late payment of assessments.

The plan of operation shall provide for imposition of an interest penalty for late payment of assessments.

(h) Deferment of payment of assessment.

(1) (i) A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the Board.

(ii) The request for deferment shall be made in writing to the Commissioner within 15 days after receipt of the assessment notice.

(2) The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that payment of the assessment would place the reinsuring carrier in a financially impaired condition.

(3) (i) Any amount deferred shall be assessed against the other reinsuring carriers in a manner consistent with the basis for assessment set forth in this section.

(ii) The reinsuring carrier receiving the deferment shall remain liable to the Pool for the amount deferred and may not reinsure any individuals or groups in the Pool until it pays that amount.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 709(d) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

In subsection (c)(4) of this section, the former phrase "from time to time" is deleted as included in the discretion of the Board to change the assessment formula.

In subsection (c)(5) of this section, the reference to "assessment shares" is substituted for the former reference to "shares of the assessment base" for consistency within this section.

In subsection (c)(6) of this section, the reference to the "Health Maintenance Organization Act of 1973" is substituted for the former reference to "42 U.S.C. § 300, et seq." to use the short title of the Act and to conform to the citation of other federal laws in other revised articles of the Code.

In subsections (d)(2) and (3)(v) and (h)(3)(ii) of this section, the references to the "Pool" are substituted for the former references to the "program" because there is no "program" of reinsurance, only the "Pool".

In subsection (f) of this section, the reference to the "assessment share" is substituted for the former reference to each reinsuring carrier's "proportion of the assessment" for consistency within this section.

In subsection (h)(3)(i) of this section, the reference to "reinsuring carriers" is substituted for the former reference to "participating carriers" to allow the use of the defined term. A reinsuring carrier is one "that participates in the Pool".

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Also in subsection (h)(3)(i) of this section, the former introductory claim, "[i]f all or part of an assessment against a reinsuring carrier is deferred" is deleted as surplusage.

Defined terms: "Board" § 1
"Carrier" § 1
"Commissioner" IN § 1-101
"Health benefit plan" § 1
"Insurer" IN § 1-101
"Pool" § 1
"Premium" IN § 1-101
"Reinsuring carrier" § 1

17. Immunity of Pool and reinsuring carriers.

Participation in the Pool as reinsuring carriers, establishment of rates, forms, or procedures, or any other joint or collective action required by §§ 14, 15, and 16 of this subheading may not be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its reinsuring carriers either jointly or separately.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 709(e) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).
The references to the "Pool" are substituted for the former references to the "program" because there is no "program" of reinsurance, only the "Pool".

Defined terms: "Pool" § 1
"Reinsuring carrier" § 1

18. Dissolution of Pool.

The Commissioner may order the dissolution of the Pool if the Commissioner determines that the Pool is not financially viable, and provision is made to ensure the protection of those insured by the members of the Pool.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 707(k) (effective subject to Ch. 9, §§ 5 and 7, Acts of 1993, as amended by Ch. 258, § 3, Acts of 1994).

Defined terms: "Commissioner" IN § 1-101
"Pool" § 1

SECTION 16. AND BE IT FURTHER ENACTED, That, subject to the approval of the Director of the Department of Legislative Reference, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act.

SECTION 17. AND BE IT FURTHER ENACTED, That the Revisor's Notes and catchlines contained in this Act are not law and may not be considered to have been enacted as a part of this Act.

SECTION 18. AND BE IT FURTHER ENACTED, That, at the end of May 31, 1998, and with no further action required by the General Assembly, § 15-111 of the Insurance Article, as enacted by Ch. _____ (H.B. 11) of the Acts of the General Assembly of 1997, shall be void and § 15-111 of the Insurance Article, as enacted by Section 3 of this Act, shall take effect. This section supersedes the termination and abrogation provisions of Section 3 of Chapter 462 of the Acts of the General Assembly of 1995.

SECTION 19. AND BE IT FURTHER ENACTED, That, at the end of December 31, 2000, and with no further action required by the General Assembly, § 24-207 of the Insurance Article, as enacted by Chapter 11 of the Acts of the General Assembly of 1996, shall be void and § 24-207 of the Insurance Article, as enacted by Section 4 of this Act, shall take effect. This section supersedes the termination and abrogation provisions of Section 4 of Chapter 50 of the Acts of the General Assembly of 1995.

SECTION 20. AND BE IT FURTHER ENACTED, That Section 14 of this Act shall take effect on the taking effect of the termination provision specified in Section 2 of Chapter 271 of the Acts of the General Assembly of 1996. This Act may not be interpreted to have any effect on that termination provision.

SECTION 21. AND BE IT FURTHER ENACTED, That Section 15 of this Act is contingent on the taking effect of Sections 5 and 7 of Chapter 9 of the Acts of the General Assembly of 1993, as amended by Section 3 of Chapter 258 of the Acts of the General Assembly of 1994. If those contingencies are met, Section 15 of this Act shall take effect.

SECTION 22. AND BE IT FURTHER ENACTED, That, except for Sections 18, 19, 20, and 21 of this Act, this Act shall take effect October 1, 1997.