

SENATE BILL 893

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4r3097
CF HB 823

By: **Chair, Finance Committee (By Request – Department of Legislative Services)**

Introduced and read first time: January 31, 2014

Assigned to: Finance

Committee Report: Favorable

Senate action: Adopted

Read second time: March 8, 2014

CHAPTER _____

1 AN ACT concerning

2 **Health Insurance – Insurance Laws That Apply to Health Maintenance**
3 **Organizations – Consolidation and Clarification**

4 FOR the purpose of consolidating the insurance laws of the State that apply to health
5 maintenance organizations; clarifying the application of the insurance laws of
6 the State to health maintenance organizations; repealing certain obsolete
7 provisions of law; declaring the intent of the General Assembly; making
8 conforming changes; and generally relating to health maintenance
9 organizations and the insurance laws of the State.

10 BY repealing and reenacting, with amendments,
11 Article – Health – General
12 Section 19–706
13 Annotated Code of Maryland
14 (2009 Replacement Volume and 2013 Supplement)

15 BY repealing and reenacting, with amendments,
16 Article – Insurance
17 Section 2–112, 5–608(t), 15–118, 15–401 through 15–403.1, 15–803, 15–818,
18 15–823, 15–903, 15–1501, 27–209, 27–302 through 27–304, 27–305(c),
19 27–504, and 27–606
20 Annotated Code of Maryland
21 (2011 Replacement Volume and 2013 Supplement)

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.



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

3 **Article – Health – General**

4 19–706.

5 (a) Each health maintenance organization that is issued a certificate of
6 authority by the Commissioner shall be regulated under this subtitle.

7 (b) (1) Any health maintenance organization that is regulated by Title 14,
8 Subtitle 1 of the Insurance Article is subject also to this subtitle.

9 (2) This subsection applies to a corporation described in Title 14,
10 Subtitle 1 of the Insurance Article, but only if it is a health maintenance organization.

11 (c) Except as otherwise provided in this subtitle **OR EXPRESSLY PROVIDED**
12 **IN THE INSURANCE ARTICLE**, a health maintenance organization is not subject to
13 the insurance laws of this State.

14 **DRAFTER’S NOTE:**

15 HG, § 19–706(c) is revised to expand the applicability of the insurance laws of
16 the State to provisions in the Insurance Article that expressly apply to health
17 maintenance organizations (HMOs). The revision is necessary in light of the repeal, as
18 enacted by this Act, of cross–references in HG, § 19–706 to provisions of the Insurance
19 Article.

20 [(d) (1) The provisions of § 9–231 and Title 9, Subtitle 1 and Title 10,
21 Subtitle 1 of the Insurance Article shall apply to health maintenance organizations.

22 (2) The provisions of § 15–815 of the Insurance Article shall apply to
23 health maintenance organizations.]

24 **DRAFTER’S NOTE:**

25 HG, § 19–706(d)(1) is repealed in light of IN, § 9–231(b)(4), which provides that
26 the provisions of § 9–231 that apply to insurers also apply to HMOs; IN, § 9–101,
27 which provides that the provisions of Title 9, Subtitle 1 that apply to authorized
28 insurers also apply to HMOs; and IN, § 10–102(a)(3), which provides that Title 10,
29 Subtitle 1 applies to all types of insurers, including HMOs.

30 HG, § 19–706(d)(2) is repealed in light of IN, § 15–815(b)(2), which provides that
31 § 15–815 applies to contracts issued by HMOs.

1 [(e) A health maintenance organization which enrolls members eligible for
2 Medicare benefits under Title XVIII of the Social Security Act shall be subject to the
3 requirements of Title 15, Subtitle 9 of the Insurance Article, to the extent any of the
4 provisions of Title 15, Subtitle 9 of the Insurance Article are applicable to the
5 Medicare eligible members.]

6 DRAFTER'S NOTE:

7 HG, § 19-706(e) is repealed in light of IN, § 15-903(c) which, as enacted by
8 Section 2 of this Act, is substantively identical to § 19-706(e).

9 [(f)] (D) Only the Commissioner may issue, suspend, or revoke a certificate
10 of authority of a health maintenance organization.

11 [(g) The provisions of § 27-504 and Title 27, Subtitle 3 of the Insurance
12 Article shall apply to health maintenance organizations.]

13 DRAFTER'S NOTE:

14 HG, § 19-706(g) is repealed in light of the inclusion of HMOs in the substantive
15 provisions of IN, § 27-504(b) and, as enacted by Section 2 of this Act, IN, § 27-504(e);
16 IN, § 27-302(a), which, as enacted by Section 2 of this Act, provides that Title 27,
17 Subtitle 3 applies to each individual or group contract or certificate of an HMO; and
18 the inclusion of HMOs in the substantive provisions of IN, §§ 27-303, 27-304, and
19 27-305(c)(1), as enacted by Section 2 of this Act.

20 Note that the application of all provisions of IN, § 27-504 to HMOs under HG, §
21 19-706(g) is overly broad in that § 27-504(c) and (d) apply only to the issuance of life
22 and disability insurance.

23 [(h) The provisions of §§ 15-401, 15-402, 15-403, 15-403.1, and 15-405 of the
24 Insurance Article shall apply to health maintenance organizations.]

25 DRAFTER'S NOTE:

26 HG, § 19-706(h) is repealed in light of IN, § 15-401(b)(1)(iv) and (v), which, as
27 enacted by Section 2 of this Act, provides that § 15-401(b) applies to each individual
28 and group contract that provides certain coverage and is delivered, issued for delivery,
29 or renewed in the State by an HMO; the inclusion of HMOs in the substantive
30 provisions of IN, § 15-401(c), (d), (g), and (h), as enacted by Section 2 of this Act; IN, §
31 15-402(a)(2), which, as enacted by Section 2 of this Act, provides that IN, § 15-402
32 applies to each contract that is issued in the State by an HMO; IN, § 15-403(a)(4) and
33 (5), which, as enacted by Section 2 of this Act, provides that § 15-403 applies to each
34 individual and group contract that provides certain coverage and is issued by an HMO;
35 the inclusion of HMOs in the substantive provisions of IN, § 15-403(c) and (d), as
36 enacted by Section 2 of this Act; IN, § 15-403.1(a)(4) and (5), which, as enacted by

1 Section 2 of this Act, provides that § 15–403.1 applies to each individual and group
2 contract that provides certain coverage and is issued by an HMO; the inclusion of
3 HMOs in the substantive provisions of IN, § 15–403.1(c) and (d), as enacted by Section
4 2 of this Act; IN, § 15–405(a)(2), which includes an HMO in the defined term “carrier”
5 for purposes of § 15–405; and IN, § 15–405(b)(1), which provides that § 15–405 applies
6 to HMOs.

7 [(i) The provisions of §§ 12–203(g), 15–105, 15–112, 15–112.2, 15–113,
8 15–804, 15–812, 15–826, 15–828, and 15–836 of the Insurance Article shall apply to
9 health maintenance organizations.]

10 DRAFTER’S NOTE:

11 HG, § 19–706(i) is repealed in light of the inclusion of HMOs in the substantive
12 provisions of IN, § 12–203(g); IN, § 15–105(b)(2), which provides that § 15–105 applies
13 to HMOs; IN, §§ 15–112(a)(4)(i), 15–112.2(a)(3), and 15–113(a)(2), which include an
14 HMO in the defined term “carrier” for purposes of §§ 15–112, 15–112.2, and 15–113;
15 IN, § 15–804(c)(1), which provides that § 15–804(c) applies to a contract issued by an
16 HMO; the inclusion of HMOs in the substantive provisions of IN, § 15–804(d); and IN,
17 §§ 15–812(b)(2), 15–826(a)(2), 15–828(a)(2), and 15–836(a)(2), which provide that §§
18 15–812, 15–826, 15–828, and 15–836 apply to HMOs.

19 [(j) The provisions of Title 15, Subtitle 12 of the Insurance Article shall apply
20 to health maintenance organizations.]

21 DRAFTER’S NOTE:

22 HG, § 19–706(j) is repealed in light of IN, § 15–1201(c), which includes an HMO
23 in the defined term “carrier” for purposes of Title 15, Subtitle 12; IN, § 15–1201(i)(1),
24 which includes an HMO subscriber or group master contract in the defined term
25 “health benefit plan” for purposes of Title 15, Subtitle 12; and the inclusion of HMOs
26 in the substantive provisions of IN, §§ 15–1204(f), 15–1205(e)(2), 15–1210(b),
27 15–1212(b)(5), 15–1216(c)(2), 15–1217(b), and 15–1221(c)(6).

28 [(k) The provisions of § 27–909 of the Insurance Article shall apply to health
29 maintenance organizations.]

30 DRAFTER’S NOTE:

31 HG, § 19–706(k) is repealed in light of the inclusion of HMOs in the substantive
32 provisions of IN, § 27–909(c) and (f).

33 [(l) (1) A health maintenance organization shall:

34 (i) Classify an obstetrician/gynecologist as a primary care
35 physician; or

1 (ii) If the obstetrician/gynecologist chooses not to be a primary
2 care physician, permit a woman to receive gynecological care from an in-network
3 obstetrician/gynecologist without requiring the woman to first visit a primary care
4 provider, provided that:

5 1. The care is medically necessary, including, but not
6 limited to, care that is routine;

7 2. Following each visit for gynecological care, the
8 obstetrician/gynecologist communicates with the woman's primary care physician
9 concerning any diagnosis or treatment rendered; and

10 3. The obstetrician/gynecologist confers with the
11 primary care physician before performing any diagnostic procedure that is not routine
12 gynecological care rendered during an annual visit.

13 (2) If a health maintenance organization classifies an
14 obstetrician/gynecologist as a primary care physician as provided under paragraph (1)
15 of this subsection, and a woman does not choose an obstetrician/gynecologist as her
16 primary care provider, the health maintenance organization shall permit the woman
17 to receive an annual visit to an in-network obstetrician/gynecologist for routine
18 gynecological care without requiring the woman to first visit her primary care
19 provider, whether or not the primary care provider is qualified to and regularly
20 provides routine gynecological care.

21 (3) (i) A health maintenance organization shall allow a woman to
22 receive medically necessary, routine obstetric and gynecological care from an
23 in-network, certified nurse midwife or any other in-network provider authorized
24 under the Health Occupations Article to provide obstetric and gynecological services
25 without first requiring the woman to visit a primary care provider.

26 (ii) A certified nurse midwife or other nonphysician provider
27 authorized under the Health Occupations Article to provide obstetric and
28 gynecological services shall consult with an obstetrician/gynecologist with whom the
29 certified nurse midwife or other provider has a collaborative agreement, in accordance
30 with the collaborative agreement, regarding any care rendered under this paragraph.]

31 DRAFTER'S NOTE:

32 HG, § 19-706(l) is repealed in light of IN, § 15-816, which is substantively
33 identical to § 19-706(l) and that provides in § 15-816(a)(2) that § 15-816 applies to
34 HMOs.

35 [(m) The provisions of § 15-116 of the Insurance Article apply to health
36 maintenance organizations.]

1 DRAFTER'S NOTE:

2 HG, § 19-706(m) is repealed in light of IN, § 15-116(a)(2), which includes an
3 HMO in the defined term "carrier" for purposes of § 15-116.

4 [(n) The provisions of § 15-121 of the Insurance Article shall apply to health
5 maintenance organizations.]

6 DRAFTER'S NOTE:

7 HG, § 19-706(n) is repealed in light of IN, § 15-121(a)(2), which includes an
8 HMO in the defined term "carrier" for purposes of § 15-121.

9 [(o) The provisions of §§ 15-1008 and 15-1009 of the Insurance Article apply
10 to health maintenance organizations.]

11 DRAFTER'S NOTE:

12 HG, § 19-706(o) is repealed in light of IN, §§ 15-1008(a)(2) and 15-1009(a),
13 which include an HMO in the defined term "carrier" for purposes of §§ 15-1008 and
14 15-1009.

15 [(p) The provisions of § 15-823 of the Insurance Article shall apply to health
16 maintenance organizations.]

17 DRAFTER'S NOTE:

18 HG, § 19-706(p) is repealed in light of IN, § 15-823(b)(4) which, as enacted by
19 Section 2 of this Act, provides that § 15-823 applies to each individual or group
20 contract of an HMO that is issued or delivered in the State.

21 [(q) The provisions of § 15-824 of the Insurance Article shall apply to health
22 maintenance organizations.]

23 DRAFTER'S NOTE:

24 HG, § 19-706(q) is repealed in light of IN, § 15-824(b)(2), which provides that §
25 15-824 applies to HMOs.

26 [(r) The provisions of § 15-803 of the Insurance Article shall apply to health
27 maintenance organizations.]

28 DRAFTER'S NOTE:

1 HG, § 19–706(r) is repealed in light of IN, § 15–803(a) which, as enacted by
2 Section 2 of this Act, includes HMOs that issue or deliver individual or group contracts
3 in the State in the substantive provisions of § 15–803(a).

4 [(s) The provisions of Title 15, Subtitles 13, 14, and 15 of the Insurance
5 Article apply to health maintenance organizations.]

6 DRAFTER’S NOTE:

7 HG, § 19–706(s) is repealed in light of IN, § 15–1301(e), which includes an HMO
8 in the defined term “carrier” for purposes of Title 15, Subtitle 13; IN, § 15–1301(l)(1),
9 which includes an HMO subscriber or group master contract in the defined term
10 “health benefit plan” for purposes of Title 15, Subtitle 13; the inclusion of HMOs in the
11 substantive provisions of IN, §§ 15–1308(g) and 15–1316(g); IN, § 15–1401(d), which
12 includes an HMO in the defined term “carrier” for purposes of Title 15, Subtitle 14; IN,
13 § 15–1401(j)(1), which includes an HMO subscriber or group master contract in the
14 defined term “health benefit plan” for purposes of Title 15, Subtitle 14; the inclusion
15 of HMOs in the substantive provisions of IN, §§ 15–1408(6) and 15–1409(d); IN, §
16 15–1501(a)(3)(i) which, as enacted by Section 2 of this Act, includes in the defined
17 term “mandated health insurance service” a legislative proposal or statute that would
18 require a particular health care service to be provided or offered in a health benefit
19 plan by an HMO; and the inclusion of HMOs in the substantive provisions of IN, §
20 15–1501(c)(2)(iii)4, as enacted by Section 2 of this Act.

21 [(t) The provisions of § 15–123 of the Insurance Article shall apply to health
22 maintenance organizations.]

23 DRAFTER’S NOTE:

24 HG, § 19–706(t) is repealed in light of IN, § 15–123(a)(2), which includes an
25 HMO in the defined term “carrier” for purposes of § 15–123.

26 [(u) The provisions of § 15–825 of the Insurance Article shall apply to health
27 maintenance organizations.]

28 DRAFTER’S NOTE:

29 HG, § 19–706(u) is repealed in light of IN, § 15–825(a)(2), which provides that §
30 15–825 applies to HMOs.

31 [(v) (E) The provisions of [Title 6, Subtitle 2 and] Title 27, Subtitle 8 of the
32 Insurance Article shall apply to health maintenance organizations.

33 DRAFTER’S NOTE:

1 The reference to IN, Title 6, Subtitle 2 in HG, § 19–706(v) is repealed in light of
2 IN, § 6–203(a), which establishes the fraud prevention fee the Maryland Insurance
3 Commissioner must collect from an HMO under Title 6, Subtitle 2.

4 The cross–reference to IN, Title 27, Subtitle 8 is retained in HG, § 19–706. Title
5 27, Subtitle 8 requires certain persons to report insurance fraud and an authorized
6 insurer and a viatical settlement provider to have an insurance antifraud plan. There
7 is no express reference to an HMO in Title 27, Subtitle 8, and it is unclear which
8 provisions apply to HMOs, including whether an HMO’s insurance antifraud plan
9 would need to comply with the requirements applicable to authorized insurers, which
10 differ from those applicable to viatical settlement providers. Since the application of
11 the provisions of Title 27, Subtitle 8 to HMOs is unclear, the cross–reference is
12 retained to avoid any inadvertent substantive change in the application of State
13 insurance laws to HMOs.

14 [(w) The provisions of § 15–118 of the Insurance Article shall apply to health
15 maintenance organizations.]

16 DRAFTER’S NOTE:

17 HG, § 19–706(w) is repealed in light of IN, § 15–118(b), which, as enacted by
18 Section 2 of this Act, provides that § 15–118 applies to HMOs.

19 [(x) The provisions of § 15–822 of the Insurance Article shall apply to health
20 maintenance organizations.]

21 DRAFTER’S NOTE:

22 HG, § 19–706(x) is repealed in light of IN, § 15–822(a)(2), which provides that §
23 15–822 applies to HMOs.

24 [(y) (F) The provisions of Title 15, [Subtitles 10A, 10B, 10C, and 10D]
25 **SUBTITLE 10B** of the Insurance Article shall apply to health maintenance
26 organizations.

27 DRAFTER’S NOTE:

28 The reference to IN, Title 15, Subtitles 10A, 10C, and 10D in HG, § 19–706(y) is
29 repealed in light of IN, § 15–10A–01(c), which includes an HMO in the defined term
30 “carrier” for purposes of Title 15, Subtitle 10A; the inclusion of HMOs in the
31 substantive provisions of IN, § 15–10A–04(c)(2) and (3); IN, § 15–10C–01(f)(1), which
32 defines a “medical director” to mean a physician employed by or under contract with
33 an HMO to perform specified duties related to quality assurance and utilization
34 management; the inclusion of HMOs in the substantive provisions of IN, §§
35 15–10C–03(b)(2) and 15–10C–04(a); IN, § 15–10D–01(d), which includes an HMO in
36 the defined term “carrier” and § 15–10D–01(h)(i)(iii), which includes an HMO contract

1 in the defined term “health benefit plan”, for purposes of Title 15, Subtitle 10D; and
2 the inclusion of HMOs in the substantive provisions of IN, §§ 15–10D–02(e)(1) and
3 15–10D–03(b)(2)(ii).

4 The cross–reference to IN, Title 15, Subtitle 10B is retained in HG, § 19–706.
5 While IN, §§ 15–10B–09(b) through (e) and 15–10B–17(a)(1)(i) specifically refer to
6 HMOs, Subtitle 10B generally does not apply directly to any particular insurance
7 carriers, but rather regulates the conduct of utilization review by private review
8 agents. Since the extent to which other provisions of Title 15, Subtitle 10B apply to
9 HMOs is unclear, the cross–reference is retained to avoid any inadvertent substantive
10 change in the application of State insurance laws to HMOs.

11 [(z) The provisions of § 2–112.2 of the Insurance Article shall apply to health
12 maintenance organizations.]

13 DRAFTER’S NOTE:

14 HG, § 19–706(z) is repealed in light of IN, § 2–112.2(a)(2), which includes an
15 HMO in the defined term “carrier”, and IN, § 2–112.2(a)(3)(i), which includes an HMO
16 contract in the defined term “health benefit plan”, for purposes of § 2–112.2.

17 [(aa) The provisions of § 15–827 of the Insurance Article shall apply to health
18 maintenance organizations.]

19 DRAFTER’S NOTE:

20 HG, § 19–706(aa) is repealed in light of IN, § 15–827(b)(2), which provides that
21 § 15–827 applies to HMOs.

22 [(bb) The provisions of § 15–818 of the Insurance Article shall apply to health
23 maintenance organizations.]

24 DRAFTER’S NOTE:

25 HG, § 19–706(bb) is repealed in light of IN, § 15–818(a)(3), which, as enacted by
26 Section 2 of this Act, provides that § 15–818 applies to each contract that provides
27 specified benefits and is issued or delivered in the State by an HMO.

28 [(cc) (G) The provisions of Title 6.5 of the State Government Article shall
29 apply to the acquisition of a health maintenance organization owned by a nonprofit
30 entity.]

31 [(dd) The provisions of § 15–125 of the Insurance Article apply to health
32 maintenance organizations.]

33 DRAFTER’S NOTE:

1 HG, § 19-706(dd) is repealed in light of IN, § 15-125(a)(2)(i), which includes an
2 HMO in the defined term “carrier” for purposes of § 15-125.

3 [(ee) The provisions of Title 2, Subtitle 5 and § 2-112 of the Insurance Article
4 apply to health maintenance organizations.]

5 DRAFTER’S NOTE:

6 HG, § 19-706(ee) is repealed in light of IN, § 2-501(d)(2), which includes an
7 HMO in the defined term “health insurer” and IN, § 2-501(f)(2), which includes an
8 HMO in the defined term “insurer”, for purposes of Title 2, Subtitle 5; IN, § 2-112(a),
9 which, as enacted by Section 2 of this Act, provides that the “appropriate persons” that
10 must pay the fees collected by the Maryland Insurance Commissioner under §
11 2-112(a) includes an HMO; IN, § 2-112(a)(10), which, as enacted by Section 2 of this
12 Act, includes a cross-reference to § 19-708(b)(12) of the Health – General Article, the
13 legal service of process provision applicable to HMOs; and the inclusion of HMOs in
14 the substantive provisions of IN, § 2-112(b), as enacted by Section 2 of this Act.
15 According to the Maryland Insurance Administration, the changes made to IN, §
16 2-112(a)(10) and (b) clarify current practice and are not substantive.

17 [(ff) The provisions of § 15-829 of the Insurance Article shall apply to health
18 maintenance organizations.]

19 DRAFTER’S NOTE:

20 HG, § 19-706(ff) is repealed in light of IN, § 15-829(b)(2), which provides that §
21 15-829 applies to HMOs.

22 [(gg) The provisions of §§ 15-830, 15-831, and 15-832 of the Insurance Article
23 shall apply to health maintenance organizations.]

24 DRAFTER’S NOTE:

25 HG, § 19-706(gg) is repealed in light of IN, § 15-830(a)(2), which includes an
26 HMO in the defined term “carrier” for purposes of § 15-830; IN, § 15-831(b)(1)(ii) and
27 (2), which provide that § 15-831 applies to HMOs and that HMOs are subject to the
28 requirements of § 15-831; and IN, § 15-832(a)(2), which provides that § 15-832
29 applies to HMOs.

30 [(hh) The provisions of § 15-833 of the Insurance Article shall apply to health
31 maintenance organizations.]

32 DRAFTER’S NOTE:

1 HG, § 19–706(hh) is repealed in light of IN, § 15–833(b), which provides that §
2 15–833 applies to health benefit plans issued under IN, Title 15, Subtitle 12 (IN, §
3 15–1201(f)(1) includes an HMO subscriber or group master contract in the defined
4 term “health benefit plan”), and IN, § 15–833(e)(1)(ii), (f)(1)(ii), (h)(1), and (j)(1), which
5 provide that subsections (e), (f), (h), and (j) apply to HMOs.

6 Note that the application of all provisions of IN, § 15–833 to HMOs under HG, §
7 19–706(hh) is overly broad in that § 15–833(g) applies to policies that limit coverage to
8 hospital or surgical benefits and hospital indemnity policies, and § 15–833(i) applies to
9 insurers that provide accidental death or dismemberment benefits.

10 [(ii) The provisions of § 15–834 of the Insurance Article apply to health
11 maintenance organizations.]

12 DRAFTER’S NOTE:

13 HG, § 19–706(ii) is repealed in light of IN, § 15–834(a)(2), which provides that §
14 15–834 applies to HMOs.

15 [(jj) The provisions of § 15–126 of the Insurance Article apply to health
16 maintenance organizations.]

17 DRAFTER’S NOTE:

18 HG, § 19–706(jj) is repealed in light of IN, § 15–126(b)(2), which provides that §
19 15–126 applies to HMOs.

20 [(kk) The provisions of §§ 15–1003, 15–1004, and 15–1005 of the Insurance
21 Article apply to health maintenance organizations.]

22 DRAFTER’S NOTE:

23 HG, § 19–706(kk) is repealed in light of the inclusion of HMOs in the
24 substantive provisions of IN, §§ 15–1003(d)(2)(ii), 15–1004(a) and (c) through (f), and
25 15–1005(b) through (f); and IN, § 15–1004(a)(1), which requires an HMO to accept the
26 uniform claims form adopted by the Maryland Insurance Commissioner under IN, §
27 15–1003.

28 [(ll) The provisions of § 15–303(f) of the Insurance Article apply to health
29 maintenance organizations.]

30 DRAFTER’S NOTE:

31 HG, § 19–706(ll) is repealed in light of Chapter 602 of the Acts of 1999, which
32 repealed IN, § 15–303.

1 [(mm) The provisions of § 15–127 of the Insurance Article shall apply to
2 health maintenance organizations.]

3 DRAFTER’S NOTE:

4 HG, § 19–706(mm) is repealed in light of IN, § 15–127(a)(4), which includes an
5 HMO in the defined term “carrier” for purposes of § 15–127.

6 [(nn) The provisions of § 15–835 of the Insurance Article shall apply to health
7 maintenance organizations.]

8 DRAFTER’S NOTE:

9 HG, § 19–706(nn) is repealed in light of IN, § 15–835(b)(2), which provides that
10 § 15–835 applies to HMOs.

11 [(oo) The provisions of § 15–810 of the Insurance Article apply to health
12 maintenance organizations.]

13 DRAFTER’S NOTE:

14 HG, § 19–706(oo) is repealed in light of IN, § 15–810(a)(2), which provides that §
15 15–810 applies to HMOs, and the inclusion of HMOs in the substantive provisions of
16 IN, § 15–810(b)(2)(ii).

17 [(pp) The provisions of § 27–913 of the Insurance Article apply to health
18 maintenance organizations.]

19 DRAFTER’S NOTE:

20 HG, § 19–706(pp) is repealed in light of IN, § 27–913(a)(2), which provides that
21 § 27–913 applies to HMOs.

22 [(qq) The provisions of §§ 2–205, 2–207, 2–208, and 2–209 of the Insurance
23 Article apply to health maintenance organizations.]

24 DRAFTER’S NOTE:

25 HG, § 19–706(qq) is repealed in light of the inclusion of HMOs in the
26 substantive provisions of IN, §§ 2–205(b), (c), and (f) and 2–207(a); IN, § 2–208, which
27 requires the expense incurred in an examination made under IN, § 2–205 to be paid by
28 the person examined in the manner specified in § 2–208; and IN, § 2–209(a), which
29 requires a complete report of each examination made under IN, § 2–205.

30 [(rr) The provisions of § 15–837 of the Insurance Article apply to health
31 maintenance organizations.]

1 DRAFTER'S NOTE:

2 HG, § 19-706(rr) is repealed in light of IN, § 15-837(a)(2), which provides that §
3 15-837 applies to HMOs.

4 [(ss) The provisions of § 15-130 of the Insurance Article apply to health
5 maintenance organizations.]

6 DRAFTER'S NOTE:

7 HG, § 19-706(ss) is repealed in light of IN, § 15-130(a)(1)(ii), which provides
8 that § 15-130 applies to HMOs, except the HMOs described in § 15-130(a)(2)(iii).

9 [(tt) The requirements of § 15-838 of the Insurance Article apply to health
10 maintenance organizations.]

11 DRAFTER'S NOTE:

12 HG, § 19-706(tt) is repealed in light of IN, § 15-838(a)(2), which provides that §
13 15-838 applies to HMOs.

14 [(uu) The provisions of § 15-839 of the Insurance Article apply to health
15 maintenance organizations.]

16 DRAFTER'S NOTE:

17 HG, § 19-706(uu) is repealed in light of IN, § 15-839(b)(2), which provides that
18 § 15-839 applies to HMOs.

19 [(vv) The provisions of § 15-1001 of the Insurance Article shall apply to health
20 maintenance organizations.]

21 DRAFTER'S NOTE:

22 HG, § 19-706(vv) is repealed in light of IN, § 15-1001(a)(3), which provides that
23 § 15-1001 applies to HMOs.

24 [(ww) The provisions of § 27-606 of the Insurance Article apply to health
25 maintenance organizations.]

26 DRAFTER'S NOTE:

27 HG, § 19-706(ww) is repealed in light of the inclusion of HMOs in the
28 substantive provisions of IN, § 27-606(g) and IN, § 27-606(h) which, as enacted by

1 Section 2 of this Act, provides that the provisions of § 27–606(a)(3) and (b) through (f)
2 that apply to insurers also apply to HMOs.

3 [(xx) The requirements of Title 27, Subtitle 4 of the Insurance Article apply to
4 health maintenance organizations.]

5 DRAFTER’S NOTE:

6 HG, § 19–706(xx) is repealed in light of IN, § 27–402(3), which provides that the
7 provisions of Title 27, Subtitle 4 that apply to insurers also apply to HMOs.

8 [(yy) The provisions of § 15–840 of the Insurance Article apply to health
9 maintenance organizations.]

10 DRAFTER’S NOTE:

11 HG, § 19–706(yy) is repealed in light of IN, § 15–840(b)(2), which provides that §
12 15–840 applies to HMOs.

13 [(zz) The provisions of § 15–416 of the Insurance Article apply to health
14 maintenance organizations.]

15 DRAFTER’S NOTE:

16 HG, § 19–706(zz) is repealed in light of IN, § 15–416(a), which provides that §
17 15–416 applies to HMOs.

18 [(aaa) The provisions of § 27–501(h) of the Insurance Article apply to health
19 maintenance organizations.]

20 DRAFTER’S NOTE:

21 HG, § 19–706(aaa) is repealed in light of the inclusion of HMOs in the
22 substantive provisions of IN, § 27–501(h)(2) and (4).

23 [(bbb) The provisions of § 27–209 of the Insurance Article apply to health
24 maintenance organizations.]

25 DRAFTER’S NOTE:

26 HG, § 19–706(bbb) is repealed in light of IN, § 27–209, which, as enacted by
27 Section 2 of this Act, provides that a “person” that is prohibited from taking the
28 actions described in § 27–209 includes an HMO.

1 [(ccc) The provisions of § 15–713 of the Insurance Article apply to health
2 maintenance organizations.]

3 DRAFTER’S NOTE:

4 HG, § 19–706(ccc) is repealed in light of IN, § 15–713(a), which provides that §
5 15–713 applies to specified contracts delivered or issued for delivery in the State by
6 HMOs.

7 [(ddd) The provisions of § 27–221 of the Insurance Article apply to health
8 maintenance organizations.]

9 DRAFTER’S NOTE:

10 HG, § 19–706(ddd) is repealed in light of IN, § 27–221(a)(2) and (4), which
11 include an HMO in the defined term “carrier” and a contract issued or delivered in the
12 State by an HMO in the defined term “health coverage”, for purposes of § 27–221.

13 [(eee) The provisions of § 15–841 of the Insurance Article apply to health
14 maintenance organizations.]

15 DRAFTER’S NOTE:

16 HG, § 19–706(eee) is repealed in light of IN, § 15–841(b)(1)(ii), which provides
17 that § 15–841(b) applies to HMOs.

18 [(fff) The provisions of § 15–131 of the Insurance Article apply to health
19 maintenance organizations.]

20 DRAFTER’S NOTE:

21 HG, § 19–706(fff) is repealed in light of IN, § 15–131(a)(2), which provides that §
22 15–131 applies to HMOs.

23 [(ggg) The provisions of § 15–417 of the Insurance Article apply to health
24 maintenance organizations.]

25 DRAFTER’S NOTE:

26 HG, § 19–706(ggg) is repealed in light of IN, § 15–417(a)(2), which provides that
27 § 15–417 applies to HMOs.

28 [(hhh) The provisions of § 27–222 of the Insurance Article apply to health
29 maintenance organizations.]

1 DRAFTER'S NOTE:

2 HG, § 19-706(hhh) applies the provisions of IN, § 27-222 to HMOs. IN, §
3 27-222 prohibits a person from violating IN, § 15-112(l). HG, § 19-706(hhh) is
4 repealed in light of IN, § 15-112(a)(4)(i), which includes an HMO in the definition of
5 "carrier" for purposes of § 15-112.

6 [(iii) The provisions of § 27-914 of the Insurance Article apply to health
7 maintenance organizations.]

8 DRAFTER'S NOTE:

9 HG, § 19-706(iii) is repealed in light of the inclusion of HMOs in the
10 substantive provisions of IN, § 27-914(b).

11 [(jjj)] (H) The provisions of § 27-210 of the Insurance Article apply to health
12 maintenance organizations.

13 DRAFTER'S NOTE:

14 The cross-reference to IN, § 27-210 is retained in HG, § 19-706. Section 27-210
15 establishes certain practices that may not be construed to be discriminatory under IN,
16 § 27-208 or a rebate under § 27-209. The application of § 27-210 to HMOs is unclear
17 since IN, § 27-208 does not apply to HMOs, either by its terms or by a cross-reference
18 in HG, § 19-706 or elsewhere in Title 19, Subtitle 7, and § 27-210 does not contain
19 any explicit references to HMOs. Section 27-210 does apply to HMOs to the extent
20 that the section provides for the construction of IN, § 27-209 (which is revised in
21 Section 2 of this Act to apply to HMOs), and in that § 27-210(h) establishes that it is
22 not a rebate for a carrier to provide certain incentives for participation in a bona fide
23 wellness program under IN, § 15-509, and that section defines a "carrier" to include
24 an HMO. However, since the application of the other provisions of § 27-210 is unclear,
25 the cross-reference is retained to avoid any inadvertent substantive change in the
26 application of State insurance laws to HMOs.

27 [(kkk) The provisions of Title 14, Subtitle 6 of the Insurance Article apply to
28 health maintenance organizations.]

29 DRAFTER'S NOTE:

30 HG, § 19-706(kkk) is repealed in light of IN, § 14-602(b), which requires an
31 HMO to take several actions, including complying with specified sections of Title 14,
32 Subtitle 6, and the inclusion of HMOs in the substantive provisions of IN, §§ 14-602(c)
33 and 14-606(1)(i).

34 [(lll) The provisions of § 15-842 of the Insurance Article apply to health
35 maintenance organizations.]

1 DRAFTER'S NOTE:

2 HG, § 19-706(III) is repealed in light of IN, § 15-842(a)(1)(ii) and (2), which
3 provide that § 15-842 applies to HMOs and that HMOs are subject to the
4 requirements of § 15-842.

5 [(mmm) The provisions of §§ 15-403.2 and 15-418 of the Insurance Article
6 apply to health maintenance organizations.]

7 DRAFTER'S NOTE:

8 HG, § 19-706(mmm) is repealed in light of IN, § 15-403.2(b)(2)(ii), which
9 provides that § 14-403.2 applies to each individual or group contract issued by an
10 HMO; the inclusion of HMOs in the substantive provisions of IN, § 15-403.2(d); IN, §
11 15-418(a)(2), which includes an HMO in the defined term "carrier" for purposes of §
12 15-418; and § 15-418(b)(1)(iii), which provides that § 15-418 applies to each contract
13 that is issued in the State by an HMO.

14 [(nnn) (I) The provisions of § 15-145 of this article apply to health
15 maintenance organizations.

16 [(ooo) The provisions of § 2-115 of the Insurance Article apply to health
17 maintenance organizations.]

18 DRAFTER'S NOTE:

19 HG, § 19-706(ooo) is repealed in light of IN, § 2-115(b)(1), which provides that
20 the regulations the Maryland Insurance Commissioner is required to adopt under §
21 2-115 may apply to any person regulated by the Commissioner under Title 19,
22 Subtitle 7 of the Health – General Article.

23 [(ppp) (J) The provisions of Title 15, Subtitle 16 of the Insurance Article
24 apply to health maintenance organizations.

25 DRAFTER'S NOTE:

26 The cross-reference to IN, Title 15, Subtitle 16 is retained in HG, § 19-706.
27 Subtitle 16 governs pharmacy benefits managers and the provision of pharmacy
28 benefits management services to purchasers. While an HMO is included in the defined
29 term "purchaser", and certain services of a nonprofit HMO are excluded from the
30 definition of "pharmacy benefits management services", the extent to which other
31 provisions of Title 15, Subtitle 16 apply to HMOs is unclear. The cross-reference is
32 retained to avoid any inadvertent substantive change in the application of State
33 insurance laws to HMOs.

1 [(qqq)] (K) The provisions of § 2–517 of the State Personnel and Pensions
2 Article apply to health maintenance organizations.

3 [(rrr) The provisions of § 15–843 of the Insurance Article apply to health
4 maintenance organizations.]

5 DRAFTER’S NOTE:

6 HG, § 19–706(rrr) is repealed in light of IN, § 15–843(a)(2), which provides that
7 § 15–843 applies to HMOs, and the inclusion of HMOs in the substantive provisions of
8 IN, § 15–843(b)(3).

9 [(sss) The provisions of § 15–409.1 of the Insurance Article apply to health
10 maintenance organizations.]

11 DRAFTER’S NOTE:

12 HG, § 19–706(sss) is repealed in light of IN, § 15–409.1(a)(3), which includes an
13 HMO in the defined term “carrier” for purposes of § 15–409.1, and IN, § 15–409.1(b),
14 which provides that § 15–409.1 applies to carriers that issue health benefit plans to
15 small employers under Title 15, Subtitle 12 of the Insurance Article.

16 [(ttt) The provisions of § 15–844 of the Insurance Article apply to health
17 maintenance organizations.]

18 DRAFTER’S NOTE:

19 HG, § 19–706(ttt) is repealed in light of IN, § 15–844(b)(2), which provides that
20 § 15–844 applies to HMOs.

21 [(uuu) The provisions of § 15–1106 of the Insurance Article apply to health
22 maintenance organizations.]

23 DRAFTER’S NOTE:

24 HG, § 19–706(uuu) is repealed in light of IN, § 15–1106(a)(2), which includes an
25 HMO in the defined term “carrier” for purposes of § 15–1106.

26 [(vvv) The provisions of § 15–832.1 of the Insurance Article apply to health
27 maintenance organizations.]

28 DRAFTER’S NOTE:

29 HG, § 19–706(vvv) is repealed in light of IN, § 15–832.1(b)(2), which provides
30 that § 15–832.1 applies to HMOs.

1 [(www) The provisions of § 15–1105 of the Insurance Article apply to health
2 maintenance organizations.]

3 DRAFTER’S NOTE:

4 HG, § 19–706(www) is repealed in light of Chapter 368 of the Acts of 2013,
5 which repealed IN, § 15–1105.

6 [(xxx) The provisions of § 15–814 of the Insurance Article apply to health
7 maintenance organizations.]

8 DRAFTER’S NOTE:

9 HG, § 19–706(xxx) is repealed in light of IN, § 15–814(a)(2), which provides that
10 § 15–814 applies to HMOs.

11 [(yyy) The provisions of § 15–509 of the Insurance Article apply to health
12 maintenance organizations.]

13 DRAFTER’S NOTE:

14 HG, § 19–706(yyy) is repealed in light of IN, § 15–509(a)(3), which includes an
15 HMO in the defined term “carrier” for purposes of § 15–509.

16 [(zzz) The provisions of § 15–132 of the Insurance Article apply to health
17 maintenance organizations.]

18 DRAFTER’S NOTE:

19 HG, § 19–706(zzz) is repealed in light of IN, § 15–132(a), which defines a
20 “carrier” to have the meaning stated in § 19–142 of the Health – General Article for
21 purposes of § 15–132. A “carrier” is defined in HG, § 19–142(b) to include an HMO.

22 [(aaaa) The provisions of Title 15, Subtitle 17 of the Insurance Article apply to
23 health maintenance organizations.]

24 DRAFTER’S NOTE:

25 HG, § 19–706(aaaa) is repealed in light of IN, § 15–1701(b), which defines a
26 “carrier” to have the meaning stated in § 15–1301 of the Insurance Article for purposes
27 of Title 15, Subtitle 17. A “carrier” is defined in IN, § 15–1301(e) to include an HMO.

28 [(bbbb)] (L) The provisions of § 15–134 of the Insurance Article apply to health
29 maintenance organizations.

30 DRAFTER’S NOTE:

1 The cross-reference to IN, § 15–134 is retained in HG, § 19–706. Section
2 15–134 governs the application of IN, Titles 14 and 15 to a group health plan or health
3 insurance coverage that is a “grandfathered health plan”, as defined in the federal
4 Patient Protection and Affordable Care Act, as amended by the federal Health Care
5 and Education Reconciliation Act of 2010. This section does not by its terms apply to
6 any particular insurance carriers, but rather to certain group health plans and health
7 insurance coverage. Since the application of § 15–134 to HMOs is unclear, the
8 cross-reference is retained to avoid any inadvertent substantive change in the
9 application of State insurance laws to HMOs.

10 [(cccc) The provisions of § 5–608(t) of the Insurance Article apply to health
11 maintenance organizations.]

12 DRAFTER’S NOTE:

13 HG, § 19–706(cccc) is repealed in light of IN, § 5–608(t)(10), which, as enacted
14 by Section 2 of this Act, provides that the provisions of § 5–608(t) that apply to
15 insurers also apply to HMOs.

16 [(dddd) The requirements of § 15–135 of the Insurance Article apply to health
17 maintenance organizations.]

18 DRAFTER’S NOTE:

19 HG, § 19–706(dddd) is repealed in light of IN, § 15–135(b)(2), which provides
20 that § 15–135 applies to HMOs.

21 [(eeee) The provisions of Title 15, Subtitle 19 of the Insurance Article apply to
22 health maintenance organizations.]

23 DRAFTER’S NOTE:

24 HG, § 19–706(eeee) is repealed in light of IN, § 15–1901(b), which includes an
25 HMO in the defined term “carrier” for purposes of Title 15, Subtitle 19.

26 [(ffff) The provisions of § 15–136 of the Insurance Article apply to health
27 maintenance organizations.]

28 DRAFTER’S NOTE:

29 HG, § 19–706(ffff) is repealed in light of IN, § 15–136(a)(2), which includes an
30 HMO in the defined term “carrier” for purposes of § 15–136.

31 [(gggg) The provisions of § 15–1314 of the Insurance Article apply to health
32 maintenance organizations.]

1 DRAFTER'S NOTE:

2 HG, § 19-706(gggg) is repealed in light of IN, § 15-1301(e), which includes an
3 HMO in the defined term "carrier" for purposes of Title 15, Subtitle 13. Note that HG,
4 § 19-706(s) provided that IN, Title 15, Subtitle 13 applies to HMOs, so that §
5 19-706(gggg) is unnecessary.

6 [(hhhh) The provisions of Title 15, Subtitle 18 of the Insurance Article apply to
7 health maintenance organizations.]

8 DRAFTER'S NOTE:

9 HG, § 19-706(hhhh) is repealed in light of IN, § 15-1801(b), which includes an
10 HMO in the defined term "carrier" for purposes of Title 15, Subtitle 18, and the
11 inclusion of HMOs in the substantive provisions of IN, § 15-1802(b)(2).

12 [(iiii) The provisions of § 15-137.1 of the Insurance Article apply to health
13 maintenance organizations.]

14 DRAFTER'S NOTE:

15 HG, § 19-706(iiii) is repealed in light of the inclusion of HMOs in the
16 substantive provisions of IN, § 15-137.1(a) and (b).

17 [(jjjj) The provisions of § 15-845 of the Insurance Article apply to health
18 maintenance organizations.]

19 DRAFTER'S NOTE:

20 HG, § 19-706(jjjj) is repealed in light of IN, § 15-845(a)(2), which provides that
21 § 18-845 applies to HMOs.

22 [(kkkk) The provisions of § 15-138 of the Insurance Article apply to health
23 maintenance organizations.]

24 DRAFTER'S NOTE:

25 HG, § 19-706(kkkk) is repealed in light of IN, § 15-138(a)(5), which includes an
26 HMO in the defined term "carrier" for purposes of § 15-138, and the inclusion of
27 HMOs in the substantive provisions of § 15-138(c) and (e)(1).

28 [(llll) The provisions of § 15-846 of the Insurance Article apply to health
29 maintenance organizations.]

30 DRAFTER'S NOTE:

1 HG, § 19-706(l) is repealed in light of IN, § 15-846(b)(2), which provides that
2 § 15-846 applies to HMOs.

3 [(mmm) The provisions of § 15-139 of the Insurance Article apply to health
4 maintenance organizations.]

5 DRAFTER’S NOTE:

6 HG, § 19-706(m) is repealed in light of IN, § 15-139(b)(2), which provides
7 that § 15-139 applies to HMOs.

8 [(nnn) The provisions of § 15-135.1 of the Insurance Article apply to health
9 maintenance organizations.]

10 DRAFTER’S NOTE:

11 HG, § 19-706(n) is repealed in light of IN, § 15-135.1(a)(2), which includes
12 an HMO in the defined term “carrier” for purposes of § 15-135.1.

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

15 **Article – Insurance**

16 2-112.

17 (a) Fees for the following certificates, licenses, and services shall be collected
18 in advance by the Commissioner, and shall be paid by the appropriate persons,
19 **INCLUDING HEALTH MAINTENANCE ORGANIZATIONS**, to the Commissioner:

20 (1) fees for certificates of authority:

21 (i) application fee for initial certificate of authority, including
22 filing the application, articles of incorporation and other charter documents, except as
23 provided in item (2) of this subsection, bylaws, financial statement, examination
24 report, power of attorney to the Commissioner, and all other documents and filings in
25 connection with the application \$1,000

26 (ii) fee for initial certificate of authority \$200

27 (iii) fee for annual renewal of certificate of authority for all
28 foreign insurers and for domestic insurers with their home or executive office in the
29 State\$500

1 (iv) fee for annual renewal of certificate of authority for domestic
 2 insurers with their home or executive office outside the State, except those domestic
 3 insurers that had their home or executive office outside the State before January 1,
 4 1929:

5 1. with premiums written in the most recent calendar
 6 year not exceeding \$500,000.....\$2,500

7 2. with premiums written in the most recent calendar
 8 year not exceeding \$1,000,000.....\$5,000

9 3. with premiums written in the most recent calendar
 10 year not exceeding \$2,000,000.....\$7,000

11 4. with premiums written in the most recent calendar
 12 year not exceeding \$5,000,000.....\$9,000

13 5. with premiums written in the most recent calendar
 14 year of more than \$5,000,000.....\$11,000

15 (v) reinstatement of certificate of authority..... \$500

16 (2) fees for articles of incorporation of a domestic insurer or foreign
 17 insurer, exclusive of fees required to be paid to the Department of Assessments and
 18 Taxation:

19 (i) fee for filing the articles of incorporation with the
 20 Commissioner for approval \$25

21 (ii) fee for amendment of the articles of incorporation..... \$10

22 (3) fees for filing bylaws or amendments to bylaws with the
 23 Commissioner.....\$10

24 (4) fees for certificates of qualification:

25 (i) application fee \$25

26 (ii) managing general agent certificate of qualification:

27 1. fee for initial certificate..... \$30

28 2. annual renewal fee \$30

29 (iii) surplus lines broker certificate of qualification:

SENATE BILL 893

| | | | | |
|----|------------------------|----|---|-------|
| 1 | | 1. | fee for initial certificate within 1 year of | |
| 2 | renewal..... | | | \$100 |
| 3 | | 2. | fee for initial certificate over 1 year from | |
| 4 | renewal..... | | | \$100 |
| 5 | | 3. | biennial renewal fee | \$200 |
| 6 | (5) | | fee for temporary insurance producer licenses and | |
| 7 | appointments..... | | | \$27 |
| 8 | (6) | | fees for licenses: | |
| 9 | (i) | | public adjuster license: | |
| 10 | | 1. | fee for initial license within 1 year of renewal..... | \$25 |
| 11 | | 2. | fee for initial license over 1 year from renewal..... | \$50 |
| 12 | | 3. | biennial renewal fee | \$50 |
| 13 | (ii) | | adviser license: | |
| 14 | | 1. | fee for initial license within 1 year of renewal..... | \$100 |
| 15 | | 2. | fee for initial license over 1 year from renewal..... | \$200 |
| 16 | | 3. | biennial renewal fee | \$200 |
| 17 | (iii) | | insurance producer license: | |
| 18 | | 1. | fee for initial license | \$54 |
| 19 | | 2. | biennial renewal fee | \$54 |
| 20 | (iv) | | SHOP Exchange navigator license: | |
| 21 | | 1. | fee for initial license | \$54 |
| 22 | | 2. | biennial renewal fee | \$54 |
| 23 | | 3. | fee for reinstatement of license..... | \$100 |
| 24 | (v) | | application fee | \$25 |
| 25 | (7) | | fee for each insurance vending machine license, for each machine, | |
| 26 | every second year..... | | | \$50 |

1 (8) fees for filing the annual statement by an unauthorized insurer
2 applying for approval to become an accepted insurer or applying for approval to
3 become an accepted reinsurer or surplus lines carrier or both..... \$1,000

4 (9) fees for required filings, including form and rate filings, under Title
5 11, Subtitles 2 through 4, Title 26, and §§ 12–203, 13–110, 14–126, and 27–613 of this
6 article.....\$125

7 (10) service of legal process fee under §§ 3–318(d), 3–319(d), and 4–107
8 of this article **AND § 19–708(B)(12) OF THE HEALTH – GENERAL**
9 **ARTICLE**.....\$15

10 (b) A court may award reimbursement of a service of process fee imposed
11 under subsection (a)(10) of this section to a prevailing plaintiff in any proceeding
12 against an insurer [or], surplus lines broker, **OR HEALTH MAINTENANCE**
13 **ORGANIZATION.**

14 5–608.

15 (t) (1) The reserve investments of an insurer may include securities
16 lending, repurchase, reverse repurchase, and dollar roll transactions with business
17 entities, subject to the requirements of paragraphs (2) through (9) of this subsection.

18 (2) (i) The insurer’s board of directors shall adopt a written plan
19 that specifies guidelines and objectives to be followed, such as:

20 1. a description of how cash received will be invested or
21 used for general corporate purposes of the insurer;

22 2. operational procedures to manage interest rate risk,
23 counterparty default risk, the conditions under which proceeds from reverse
24 repurchase transactions may be used in the ordinary course of business, and the use of
25 acceptable collateral in a manner that reflects the liquidity needs of the transaction;
26 and

27 3. the extent to which the insurer may engage in these
28 transactions.

29 (ii) The insurer shall file with the Commissioner the written
30 plan including all changes and amendments to the written plan for use in the State on
31 or before the date the plan becomes effective.

32 (3) (i) The insurer shall enter into a written agreement for all
33 transactions authorized under this subsection other than dollar roll transactions.

1 (ii) The written agreement shall require that each transaction
2 terminate no more than 1 year from its inception or on the earlier demand of the
3 insurer.

4 (iii) The agreement shall be with the business entity
5 counterparty, but for securities lending transactions, the agreement may be with an
6 agent acting on behalf of the insurer, if the agent is a qualified business entity, and if
7 the agreement:

8 1. requires the agent to enter into separate agreements
9 with each counterparty that are consistent with the requirements of this section; and

10 2. prohibits securities lending transactions under the
11 agreement with the agent or its affiliates.

12 (4) (i) Cash received in a transaction under this subsection shall be
13 invested in accordance with this subtitle and in a manner that recognizes the liquidity
14 needs of the transaction or used by the insurer for its general corporate purposes.

15 (ii) For so long as the transaction remains outstanding, the
16 insurer, its agent, or its custodian shall maintain, as to acceptable collateral received
17 in a transaction under this subsection, either physically or through the book entry
18 systems of the Federal Reserve, Depository Trust Company, Participants Trust
19 Company, or other securities depositories approved by the Commissioner:

20 1. possession of the acceptable collateral;

21 2. a perfected security interest in the acceptable
22 collateral; or

23 3. in the case of a jurisdiction outside the United States,
24 title to, or rights of a secured creditor to, the acceptable collateral.

25 (5) (i) The limitations of § 5-606(a) of this subtitle do not apply to
26 the business entity counterparty exposure created by transactions under this
27 subsection.

28 (ii) For purposes of calculations made to determine compliance
29 with this subsection, no effect will be given to the insurer's future obligation to resell
30 securities, in the case of a repurchase transaction, or to repurchase securities, in the
31 case of a reverse repurchase transaction.

32 (iii) An insurer may not enter into a transaction under this
33 subsection if, as a result of and after giving effect to the transaction:

1 1. A. the aggregate amount of securities then loaned,
2 sold to, or purchased from any one business entity counterparty under this subsection
3 would exceed 5% of its admitted assets; and

4 B. in calculating the amount sold to or purchased from a
5 business entity counterparty under repurchase or reverse repurchase transactions,
6 effect may be given to netting provisions under a master written agreement; or

7 2. the aggregate amount of all securities then loaned,
8 sold to, or purchased from all business entities under this subsection would exceed
9 40% of its admitted assets.

10 (6) (i) In a securities lending transaction, the insurer shall receive
11 acceptable collateral having a market value as of the transaction date at least equal to
12 102% of the market value of the securities loaned by the insurer in the transaction as
13 of that date.

14 (ii) If at any time the market value of the acceptable collateral
15 is less than the market value of the loaned securities, the business entity counterparty
16 shall be obligated to deliver additional acceptable collateral, the market value of
17 which, together with the market value of all acceptable collateral then held in
18 connection with the transaction, at least equals 102% of the market value of the
19 loaned securities.

20 (7) (i) In a reverse repurchase transaction, other than a dollar roll
21 transaction, the insurer shall receive acceptable collateral having a market value as of
22 the transaction date at least equal to 95% of the market value of the securities
23 transferred by the insurer in the transaction as of that date.

24 (ii) If at any time the market value of the acceptable collateral
25 is less than 95% of the market value of the securities so transferred, the business
26 entity counterparty shall be obligated to deliver additional acceptable collateral, the
27 market value of which, together with the market value of all acceptable collateral then
28 held in connection with the transaction, at least equals 95% of the market value of the
29 transferred securities.

30 (8) In a dollar roll transaction, the insurer shall receive cash in an
31 amount at least equal to the market value of the securities transferred by the insurer
32 in the transaction as of the transaction date.

33 (9) (i) In a repurchase transaction, the insurer shall receive as
34 acceptable collateral transferred securities having a market value at least equal to
35 102% of the purchase price paid by the insurer for the securities.

36 (ii) If at any time the market value of the acceptable collateral
37 is less than 100% of the purchase price paid by the insurer, the business entity
38 counterparty shall be obligated to provide additional acceptable collateral, the market

1 value of which, together with the market value of all acceptable collateral then held in
2 connection with the transaction, at least equals 102% of the purchase price.

3 (iii) Securities acquired by an insurer in a repurchase
4 transaction may not be sold in a reverse repurchase transaction, loaned in a securities
5 lending transaction, or otherwise pledged.

6 **(10) THE PROVISIONS OF THIS SUBSECTION THAT APPLY TO**
7 **INSURERS ALSO APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.**

8 15–118.

9 (a) (1) In this section the following words have the meanings indicated.

10 (2) “Health care service” means a health or medical care procedure or
11 service rendered by a provider that:

12 (i) provides testing, diagnosis, or treatment of human disease
13 or dysfunction; or

14 (ii) dispenses drugs, medical devices, medical appliances, or
15 medical goods for the treatment of human disease or dysfunction.

16 (3) “Provider” means a physician, hospital, or other person that is
17 licensed or otherwise authorized to provide health care services.

18 (b) This section applies to:

19 **(1) insurers and nonprofit health service plans that provide coverage**
20 **for health care services to individuals or groups on an expense–incurred basis under**
21 **health insurance policies or contracts that are issued or delivered in the State; AND**

22 **(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE**
23 **COVERAGE FOR HEALTH CARE SERVICES TO INDIVIDUALS OR GROUPS UNDER**
24 **CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.**

25 (c) If an entity subject to this section negotiates and enters into a contract
26 with providers to render health care services to insureds, **SUBSCRIBERS, OR**
27 **MEMBERS** at alternative rates of payment, and coinsurance payments are to be based
28 on a percentage of the fee for health care services rendered by a provider, the entity
29 shall calculate the amount of the coinsurance payment to be paid by the insured,
30 **SUBSCRIBER, OR MEMBER** exclusively from the negotiated alternative rate for the
31 health care service rendered.

1 (d) An entity subject to this section may not charge or collect from an
2 insured, **A SUBSCRIBER, OR A MEMBER** a coinsurance payment amount that is
3 greater than the amount calculated under subsection (c) of this section.

4 15-401.

5 (a) In this section, “date of adoption” means the earlier of:

6 (1) a judicial decree of adoption; or

7 (2) the assumption of custody, pending adoption, of a prospective
8 adoptive child by a prospective adoptive parent.

9 (b) (1) This subsection applies to:

10 (i) each individual health insurance policy that:

11 1. is delivered, issued for delivery, or renewed in the
12 State;

13 2. provides coverage on an expense-incurred basis; and

14 3. provides coverage for a family member of the insured;

15 (ii) each group health insurance policy, including a contract
16 issued by a nonprofit health service plan, that:

17 1. is delivered, issued for delivery, or renewed in the
18 State;

19 2. provides coverage on an expense-incurred basis for
20 employees of an employer or employers or members of a union or unions; and

21 3. provides coverage for a family member of a covered
22 employee or member; [and]

23 (iii) each individual service or indemnity contract that:

24 1. is delivered, issued for delivery, or renewed in the
25 State by a nonprofit health service plan; and

26 2. provides coverage for a family member of the
27 subscriber;

28 **(IV) EACH INDIVIDUAL CONTRACT THAT:**

1 1. **IS DELIVERED, ISSUED FOR DELIVERY, OR**
2 **RENEWED IN THE STATE BY A HEALTH MAINTENANCE ORGANIZATION; AND**

3 2. **PROVIDES COVERAGE FOR A FAMILY MEMBER OF**
4 **THE SUBSCRIBER; AND**

5 **(V) EACH GROUP CONTRACT THAT:**

6 1. **IS DELIVERED, ISSUED FOR DELIVERY, OR**
7 **RENEWED IN THE STATE BY A HEALTH MAINTENANCE ORGANIZATION;**

8 2. **PROVIDES COVERAGE FOR EMPLOYEES OF AN**
9 **EMPLOYER OR EMPLOYERS OR MEMBERS OF A UNION OR UNIONS; AND**

10 3. **PROVIDES COVERAGE FOR A FAMILY MEMBER OF**
11 **THE COVERED EMPLOYEE OR MEMBER.**

12 (2) Each policy or contract subject to this subsection shall provide that
13 the health insurance benefits applicable:

14 (i) for children or grandchildren shall be payable for a newly
15 born or newly adopted dependent child or grandchild from the moment of birth or date
16 of adoption of the child or grandchild; and

17 (ii) for a minor for whom guardianship is granted by court or
18 testamentary appointment shall be payable from the date of appointment.

19 (c) On request, an insurer or nonprofit health service plan that issues an
20 individual or group health insurance policy that provides coverage on an
21 expense-incurred basis, **OR A HEALTH MAINTENANCE ORGANIZATION THAT**
22 **ISSUES AN INDIVIDUAL OR GROUP CONTRACT**, shall offer family members' coverage
23 to an insured [or], subscriber, **OR MEMBER** regardless of the marital status of the
24 insured [or], subscriber, **OR MEMBER**.

25 (d) Each insurer [or], nonprofit health service plan, **OR HEALTH**
26 **MAINTENANCE ORGANIZATION** that issues a policy **OR CONTRACT** that does not
27 provide family members' coverage shall:

28 (1) provide notice to the policyholder **OR CONTRACT HOLDER** that
29 coverage for a newly born or newly adopted child or grandchild or a minor for whom
30 guardianship is granted by court or testamentary appointment is not provided under
31 the policy **OR CONTRACT**; and

32 (2) inform the insured, **SUBSCRIBER, OR MEMBER** of the right and
33 conditions to purchase family members' coverage under this section.

1 (e) To be eligible for coverage under this section:

2 (1) a grandchild must be a dependent, and in the court-ordered
3 custody, of the insured, **SUBSCRIBER, OR MEMBER**; and

4 (2) a minor must be a dependent and in the custody of the insured,
5 **SUBSCRIBER, OR MEMBER** as a result of a guardianship, other than a temporary
6 guardianship of less than 12 months duration, granted by court or testamentary
7 appointment.

8 (f) Coverage for a newly born or newly adopted child or grandchild or a
9 minor for whom guardianship is granted by court or testamentary appointment shall
10 consist of coverage for injury or sickness, including the necessary care and treatment
11 of medically diagnosed congenital defects and birth abnormalities.

12 (g) If payment of a specific premium or subscription fee is required to provide
13 coverage for a child or grandchild or a minor for whom guardianship is granted by
14 court or testamentary appointment, the policy or contract may require notification of a
15 birth, adoption, or appointment and payment of the required premium or fee to the
16 insurer [or], nonprofit health service plan, **OR HEALTH MAINTENANCE**
17 **ORGANIZATION** within 31 days after the date of birth, date of adoption, or date of
18 court or testamentary appointment in order to continue coverage beyond the 31-day
19 period.

20 (h) (1) An insurer [or], nonprofit health service plan, **OR HEALTH**
21 **MAINTENANCE ORGANIZATION** may require proof that the insured [or], subscriber,
22 **OR MEMBER** is the parent or grandparent of a newly born or newly adopted child or
23 grandchild or guardian of a minor under court or testamentary appointment.

24 (2) If the insurer [or], nonprofit health service plan, **OR HEALTH**
25 **MAINTENANCE ORGANIZATION** requires proof under this subsection, the insurer
26 [or], nonprofit health service plan, **OR HEALTH MAINTENANCE ORGANIZATION** shall
27 pay the cost of the proof.

28 15-402.

29 (a) This section applies to:

30 (1) each individual or group health insurance policy that is issued in
31 the State; and

32 (2) each contract that is issued in the State by a nonprofit health
33 service plan **OR A HEALTH MAINTENANCE ORGANIZATION**.

1 (b) (1) Notwithstanding any limiting age stated in a policy or contract
2 subject to this section, a child, grandchild, or individual for whom guardianship is
3 granted by court or testamentary appointment shall continue to be covered under the
4 policy or contract as a dependent of an employee, member, or other covered individual
5 if the child, grandchild, or individual under guardianship:

6 (i) is unmarried;

7 (ii) is chiefly dependent for support on the employee, member,
8 or other covered individual; and

9 (iii) at the time of reaching the limiting age, is incapable of
10 self-support because of mental or physical incapacity that started before the child,
11 grandchild, or individual under guardianship attained the limiting age.

12 (2) A child, grandchild, or individual under guardianship who is
13 covered under this section shall continue to be covered while remaining unmarried,
14 dependent, and mentally or physically incapacitated until the coverage on the
15 employee, member, or other covered individual on whom the child, grandchild, or
16 individual under guardianship is dependent terminates.

17 (c) To be eligible for coverage under this section:

18 (1) a grandchild must be a dependent, and in the court-ordered
19 custody, of the employee, member, or other covered individual; and

20 (2) an individual must be a dependent and in the custody of the
21 employee, member, or other covered individual as a result of a guardianship, other
22 than a temporary guardianship of less than 12 months duration, granted by court or
23 testamentary appointment.

24 15-403.

25 (a) This section applies to:

26 (1) each individual health insurance policy that:

27 (i) provides coverage on an expense-incurred basis; and

28 (ii) provides coverage for a family member of the insured;

29 (2) each group health insurance policy that:

30 (i) provides coverage on an expense-incurred basis for
31 employees of an employer or employers or members of a union or unions; and

1 (ii) provides coverage for a family member of a covered employee
2 or member; [and]

3 (3) each individual service or indemnity contract that:

4 (i) is issued by a nonprofit health service plan; and

5 (ii) provides coverage for a family member of the subscriber;

6 **(4) EACH INDIVIDUAL CONTRACT THAT:**

7 **(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;**

8 **AND**

9 **(II) PROVIDES COVERAGE FOR A FAMILY MEMBER OF THE**
10 **SUBSCRIBER; AND**

11 **(5) EACH GROUP CONTRACT THAT:**

12 **(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;**

13 **(II) PROVIDES COVERAGE FOR EMPLOYEES OF AN**
14 **EMPLOYER OR EMPLOYERS OR MEMBERS OF A UNION OR UNIONS; AND**

15 **(III) PROVIDES COVERAGE FOR A FAMILY MEMBER OF THE**
16 **COVERED EMPLOYEE OR MEMBER.**

17 (b) Each policy or contract subject to this section shall provide that the same
18 health insurance benefits and eligibility guidelines that apply to any covered
19 dependent are available, on request of the insured, subscriber, employee, or member,
20 to a grandchild who:

21 (1) is unmarried;

22 (2) is in the court-ordered custody of the insured, subscriber,
23 employee, or member;

24 (3) resides with the insured, subscriber, employee, or member;

25 (4) is the dependent of the insured, subscriber, employee, or member;
26 and

27 (5) has not attained the limiting age under the terms of the policy or
28 contract.

1 (c) On request, an insurer that issues an individual or group health
2 insurance policy that provides coverage on an expense-incurred basis [or], a nonprofit
3 health service plan, **OR A HEALTH MAINTENANCE ORGANIZATION** shall offer family
4 members' coverage to an insured or subscriber regardless of the marital status of the
5 insured or subscriber.

6 (d) (1) An insurer [or], nonprofit health service plan, **OR HEALTH**
7 **MAINTENANCE ORGANIZATION** may require proof that the insured or subscriber is
8 the grandparent of the grandchild.

9 (2) If the insurer [or], nonprofit health service plan, **OR HEALTH**
10 **MAINTENANCE ORGANIZATION** requires proof under this subsection, the insurer
11 [or], nonprofit health service plan, **OR HEALTH MAINTENANCE ORGANIZATION** shall
12 pay the cost of the proof.

13 15-403.1.

14 (a) This section applies to:

15 (1) each individual health insurance policy that:

16 (i) provides coverage on an expense-incurred basis; and

17 (ii) provides coverage for a family member of the insured;

18 (2) each group health insurance policy that:

19 (i) provides coverage on an expense-incurred basis for
20 employees of an employer or employers or members of a union or unions; and

21 (ii) provides coverage for a family member of a covered employee
22 or member; [and]

23 (3) each individual service or indemnity contract that:

24 (i) is issued by a nonprofit health service plan; and

25 (ii) provides coverage for a family member of the subscriber;

26 (4) **EACH INDIVIDUAL CONTRACT THAT:**

27 (I) **IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;**

28 **AND**

29 (II) **PROVIDES COVERAGE FOR A FAMILY MEMBER OF THE**
30 **SUBSCRIBER; AND**

- 1 **(5) EACH GROUP CONTRACT THAT:**
- 2 **(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;**
- 3 **(II) PROVIDES COVERAGE FOR EMPLOYEES OF AN**
4 **EMPLOYER OR EMPLOYERS OR MEMBERS OF A UNION OR UNIONS; AND**
- 5 **(III) PROVIDES COVERAGE FOR A FAMILY MEMBER OF THE**
6 **COVERED EMPLOYEE OR MEMBER.**

7 (b) Each policy or contract subject to this section shall provide that the same
8 health insurance benefits and eligibility guidelines that apply to any covered
9 dependent are available, on request of the insured, subscriber, employee, or member,
10 to an individual who:

- 11 (1) is unmarried;
- 12 (2) is under testamentary or court appointed guardianship, other than
13 temporary guardianship of less than 12 months duration, of the insured, subscriber,
14 employee, or member;
- 15 (3) resides with the insured, subscriber, employee, or member;
- 16 (4) is the dependent of the insured, subscriber, employee, or member;
- 17 and
- 18 (5) has not attained the limiting age under the terms of the policy or
19 contract.

20 (c) On request, an insurer that issues an individual or group health
21 insurance policy that provides coverage on an expense-incurred basis [or], a nonprofit
22 health service plan, **OR A HEALTH MAINTENANCE ORGANIZATION** shall offer family
23 members' coverage to an insured or subscriber regardless of the marital status of the
24 insured or subscriber.

25 (d) (1) An insurer [or], nonprofit health service plan, **OR HEALTH**
26 **MAINTENANCE ORGANIZATION** may require proof that the insured or subscriber is a
27 guardian under court or testamentary appointment.

28 (2) If the insurer [or], nonprofit health service plan, **OR HEALTH**
29 **MAINTENANCE ORGANIZATION** requires proof under this subsection, the insurer
30 [or], nonprofit health service plan, **OR HEALTH MAINTENANCE ORGANIZATION** shall
31 pay the cost of the proof.

1 (a) An insurer or nonprofit health service plan that issues or delivers an
2 individual, group, or blanket health insurance policy or contract in the State, **OR A**
3 **HEALTH MAINTENANCE ORGANIZATION THAT ISSUES OR DELIVERS AN**
4 **INDIVIDUAL OR GROUP CONTRACT IN THE STATE**, may not exclude payments for
5 blood products, both derivatives and components, that otherwise would be covered
6 under the health insurance contract.

7 (b) This section does not apply to whole blood or concentrated red blood cells.

8 15–818.

9 (a) This section applies to:

10 (1) each individual or group hospital or major medical insurance policy
11 or certificate that is delivered or issued for delivery in the State by an insurer and is
12 written on an expense–incurred basis;

13 (2) each individual or group medical or major medical contract, policy,
14 or certificate that is delivered or issued for delivery in the State by a nonprofit health
15 service plan; and

16 (3) [health maintenance organizations] **EACH CONTRACT** that
17 [provide] **PROVIDES** hospital, medical, or surgical benefits to individuals or groups
18 [under contracts that are] **AND IS** issued or delivered in the State **BY A HEALTH**
19 **MAINTENANCE ORGANIZATION.**

20 (b) A policy, contract, or certificate subject to this section shall include
21 benefits for inpatient or outpatient expenses arising from orthodontics, oral surgery,
22 and otologic, audiological, and speech/language treatment involved in the management
23 of the birth defect known as cleft lip or cleft palate or both.

24 15–823.

25 (a) (1) In this section the following words have the meanings indicated.

26 (2) “Bone mass measurement” means a radiologic or radioisotopic
27 procedure or other scientifically proven technology performed on a qualified individual
28 for the purpose of identifying bone mass or detecting bone loss.

29 (3) “Qualified individual” means:

30 (i) an estrogen deficient individual at clinical risk for
31 osteoporosis;

1 (ii) an individual with a specific sign suggestive of spinal
2 osteoporosis, including roentgenographic osteopenia or roentgenographic evidence
3 suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar
4 vertebral bodies, who is a candidate for therapeutic intervention or for an extensive
5 diagnostic evaluation for metabolic bone disease;

6 (iii) an individual receiving long-term glucocorticoid (steroid)
7 therapy;

8 (iv) an individual with primary hyperparathyroidism; or

9 (v) an individual being monitored to assess the response to or
10 efficacy of an approved osteoporosis drug therapy.

11 (b) This section applies to:

12 (1) each individual hospital or major medical insurance policy of an
13 insurer that is delivered or issued for delivery in the State and is written on an
14 expense-incurred basis;

15 (2) each group or blanket health insurance policy of an insurer that is
16 issued or delivered in the State and is written on an expense-incurred basis; [and]

17 (3) each individual or group medical or major medical contract or
18 certificate of a nonprofit health service plan that is issued or delivered in the State and
19 is written on an expense-incurred basis; AND

20 **(4) EACH INDIVIDUAL OR GROUP CONTRACT OF A HEALTH**
21 **MAINTENANCE ORGANIZATION THAT IS ISSUED OR DELIVERED IN THE STATE.**

22 (c) A policy, contract, or certificate subject to this section shall include
23 coverage for qualified individuals for reimbursement for bone mass measurement for
24 the prevention, diagnosis, and treatment of osteoporosis when the bone mass
25 measurement is requested by a health care provider for the qualified individual.

26 15-903.

27 (a) Notwithstanding any other provision to the contrary, this subtitle applies
28 to:

29 (1) Medicare supplement policies and subscriber contracts that are
30 delivered or issued for delivery in the State after July 1, 1992;

31 (2) certificates that are issued under group Medicare supplement
32 policies or subscriber contracts, which certificates have been delivered or issued for
33 delivery in the State;

1 (3) individual or group Medicare supplement policies and certificates
2 that are issued by nonprofit health service plans under Title 14, Subtitle 1 of this
3 article;

4 (4) Medicare supplement policies and certificates that are issued by
5 fraternal benefit societies under Title 8, Subtitle 4 of this article; and

6 (5) Medicare supplement group or blanket policies and certificates
7 that are issued by insurers subject to Subtitle 3 of this title.

8 (b) This subtitle does not apply to a policy of:

9 (1) one or more employers or labor organizations; or

10 (2) the trustees of a fund established by one or more employers or
11 labor organizations for employees, members, former employees, or former members.

12 **(C) A HEALTH MAINTENANCE ORGANIZATION THAT ENROLLS MEMBERS**
13 **ELIGIBLE FOR MEDICARE BENEFITS UNDER TITLE XVIII OF THE SOCIAL**
14 **SECURITY ACT IS SUBJECT TO THE REQUIREMENTS OF THIS SUBTITLE TO THE**
15 **EXTENT ANY OF THE PROVISIONS OF THIS SUBTITLE APPLY TO THE MEDICARE**
16 **ELIGIBLE MEMBERS.**

17 15–1501.

18 (a) (1) In this subtitle the following words have the meanings indicated.

19 (2) “Commission” means the Maryland Health Care Commission.

20 (3) (i) “Mandated health insurance service” means a legislative
21 proposal or statute that would require a particular health care service to be provided
22 or offered in a health benefit plan, by a carrier, **INCLUDING A HEALTH**
23 **MAINTENANCE ORGANIZATION**, or other organization authorized to provide health
24 benefit plans in the State.

25 (ii) “Mandated health insurance service”, as applicable to all
26 carriers, does not include services enumerated to describe a health maintenance
27 organization under § 19–701(g)(2) of the Health – General Article.

28 (b) This subtitle does not affect the ability of the General Assembly to enact
29 legislation on mandated health insurance services.

30 (c) (1) The Commission shall assess the social, medical, and financial
31 impacts of a proposed mandated health insurance service.

1 (2) In assessing a proposed mandated health insurance service and to
2 the extent that information is available, the Commission shall consider:

3 (i) social impacts, including:

4 1. the extent to which the service is generally utilized by
5 a significant portion of the population;

6 2. the extent to which the insurance coverage is already
7 generally available;

8 3. if coverage is not generally available, the extent to
9 which the lack of coverage results in individuals avoiding necessary health care
10 treatments;

11 4. if coverage is not generally available, the extent to
12 which the lack of coverage results in unreasonable financial hardship;

13 5. the level of public demand for the service;

14 6. the level of public demand for insurance coverage of
15 the service;

16 7. the level of interest of collective bargaining agents in
17 negotiating privately for inclusion of this coverage in group contracts; and

18 8. the extent to which the mandated health insurance
19 service is covered by self-funded employer groups of employers in the State who
20 employ at least 500 employees;

21 (ii) medical impacts, including:

22 1. the extent to which the service is generally recognized
23 by the medical community as being effective and efficacious in the treatment of
24 patients;

25 2. the extent to which the service is generally recognized
26 by the medical community as demonstrated by a review of scientific and peer review
27 literature; and

28 3. the extent to which the service is generally available
29 and utilized by treating physicians; and

30 (iii) financial impacts, including:

31 1. the extent to which the coverage will increase or
32 decrease the cost of the service;

- 1 (i) a rebate of premiums payable on the contract;
- 2 (ii) a special favor or advantage in the dividends or other
3 benefits under the contract;
- 4 (iii) paid employment or a contract for services of any kind; or
- 5 (iv) any valuable consideration or other inducement not specified
6 in the contract;

7 (3) directly or indirectly give, sell, purchase, offer or agree to give, sell,
8 or purchase, or allow as inducement to the insurance or annuity or in connection with
9 the insurance or annuity, regardless of whether specified in the policy or contract, an
10 agreement that promises returns and profits, or stocks, bonds, or other securities, or a
11 present or contingent interest in or measured by stocks, bonds, or other securities, of
12 an insurer or other corporation, association, or partnership, or dividends or profits
13 accrued or to accrue on stocks, bonds, or other securities; or

14 (4) offer, promise, or give any valuable consideration not specified in
15 the contract, except for educational materials, promotional materials, or articles of
16 merchandise that cost no more than \$25, regardless of whether a policy is purchased.

17 27-302.

18 (a) This subtitle applies to each individual or group policy, contract, or
19 certificate of an insurer [or], nonprofit health service plan, **OR HEALTH**
20 **MAINTENANCE ORGANIZATION** that:

- 21 (1) is delivered or issued in the State;
- 22 (2) is issued to a group that has a main office in the State; or
- 23 (3) covers individuals who reside or work in the State.

24 (b) This subtitle does not apply to:

- 25 (1) reinsurance;
- 26 (2) workers' compensation insurance; or
- 27 (3) surety insurance.

28 27-303.

29 It is an unfair claim settlement practice and a violation of this subtitle for an
30 insurer [or], nonprofit health service plan, **OR HEALTH MAINTENANCE**
31 **ORGANIZATION** to:

- 1 (1) misrepresent pertinent facts or policy provisions that relate to the
2 claim or coverage at issue;
- 3 (2) refuse to pay a claim for an arbitrary or capricious reason based on
4 all available information;
- 5 (3) attempt to settle a claim based on an application that is altered
6 without notice to, or the knowledge or consent of, the insured;
- 7 (4) fail to include with each claim paid to an insured or beneficiary a
8 statement of the coverage under which payment is being made;
- 9 (5) fail to settle a claim promptly whenever liability is reasonably
10 clear under one part of a policy, in order to influence settlements under other parts of
11 the policy;
- 12 (6) fail to provide promptly on request a reasonable explanation of the
13 basis for a denial of a claim;
- 14 (7) fail to meet the requirements of Title 15, Subtitle 10B of this
15 article for preauthorization for a health care service;
- 16 (8) fail to comply with the provisions of Title 15, Subtitle 10A of this
17 article;
- 18 (9) fail to act in good faith, as defined under § 27–1001 of this title, in
19 settling a first-party claim under a policy of property and casualty insurance; or
- 20 (10) fail to comply with the provisions of § 16–118 of this article.

21 27–304.

22 It is an unfair claim settlement practice and a violation of this subtitle for an
23 insurer [or], nonprofit health service plan, **OR HEALTH MAINTENANCE**
24 **ORGANIZATION**, when committed with the frequency to indicate a general business
25 practice, to:

- 26 (1) misrepresent pertinent facts or policy provisions that relate to the
27 claim or coverage at issue;
- 28 (2) fail to acknowledge and act with reasonable promptness on
29 communications about claims that arise under policies;
- 30 (3) fail to adopt and implement reasonable standards for the prompt
31 investigation of claims that arise under policies;

1 (4) refuse to pay a claim without conducting a reasonable
2 investigation based on all available information;

3 (5) fail to affirm or deny coverage of claims within a reasonable time
4 after proof of loss statements have been completed;

5 (6) fail to make a prompt, fair, and equitable good faith attempt, to
6 settle claims for which liability has become reasonably clear;

7 (7) compel insureds to institute litigation to recover amounts due
8 under policies by offering substantially less than the amounts ultimately recovered in
9 actions brought by the insureds;

10 (8) attempt to settle a claim for less than the amount to which a
11 reasonable person would expect to be entitled after studying written or printed
12 advertising material accompanying, or made part of, an application;

13 (9) attempt to settle a claim based on an application that is altered
14 without notice to, or the knowledge or consent of, the insured;

15 (10) fail to include with each claim paid to an insured or beneficiary a
16 statement of the coverage under which the payment is being made;

17 (11) make known to insureds or claimants a policy of appealing from
18 arbitration awards in order to compel insureds or claimants to accept a settlement or
19 compromise less than the amount awarded in arbitration;

20 (12) delay an investigation or payment of a claim by requiring a
21 claimant or a claimant's licensed health care provider to submit a preliminary claim
22 report and subsequently to submit formal proof of loss forms that contain substantially
23 the same information;

24 (13) fail to settle a claim promptly whenever liability is reasonably
25 clear under one part of a policy, in order to influence settlements under other parts of
26 the policy;

27 (14) fail to provide promptly a reasonable explanation of the basis for
28 denial of a claim or the offer of a compromise settlement;

29 (15) refuse to pay a claim for an arbitrary or capricious reason based on
30 all available information;

31 (16) fail to meet the requirements of Title 15, Subtitle 10B of this
32 article for preauthorization for a health care service;

33 (17) fail to comply with the provisions of Title 15, Subtitle 10A of this
34 article; or

1 (18) fail to act in good faith, as defined under § 27–1001 of this title, in
2 settling a first–party claim under a policy of property and casualty insurance.

3 27–305.

4 (c) (1) On finding a violation of this subtitle, the Commissioner may
5 require an insurer [or], nonprofit health service plan, **OR HEALTH MAINTENANCE**
6 **ORGANIZATION** to make restitution to each claimant who has suffered actual
7 economic damage because of the violation.

8 (2) Subject to paragraph (3) of this subsection, restitution may not
9 exceed the amount of actual economic damage sustained, subject to the limits of any
10 applicable policy.

11 (3) For a violation of § 27–303(9) of this subtitle, the Commissioner
12 may require restitution to an insured for the following:

13 (i) actual damages, which actual damages may not exceed the
14 limits of any applicable policy;

15 (ii) expenses and litigation costs incurred by the insured in
16 pursuing an administrative complaint under § 27–303(9) of this subtitle, including
17 reasonable attorney’s fees; and

18 (iii) interest on all actual damages, expenses, and litigation costs
19 incurred by the insured computed:

20 1. at the rate allowed under § 11–107(a) of the Courts
21 Article; and

22 2. from the date on which the insured’s claim would
23 have been paid if the insurer acted in good faith.

24 (4) The amount of attorney’s fees recovered from an insurer under
25 paragraph (3) of this subsection may not exceed one–third of the actual damages
26 recovered.

27 27–504.

28 (a) (1) In this section the following words have the meanings indicated.

29 (2) “Abuse” has the meaning stated in § 4–501 of the Family Law
30 Article.

1 (3) “Cohabitant” means an individual who has had a sexual
2 relationship with another individual with whom the individual has resided for a period
3 of at least 90 days.

4 (4) “Victim of domestic violence” means an individual who:

5 (i) has received deliberate, severe, and demonstrable physical
6 injury from a current or former spouse or current or former cohabitant; or

7 (ii) is in fear of imminent deliberate, severe, and demonstrable
8 physical injury from a current or former spouse or current or former cohabitant.

9 (b) Except as otherwise provided in this article, if an individual is a victim of
10 domestic violence or subject to abuse, an insurer, nonprofit health service plan, or
11 health maintenance organization may not use information about abuse or the
12 individual’s status as a victim of domestic violence to:

13 (1) cancel, refuse to underwrite or renew, or refuse to issue a policy of
14 life insurance or health insurance or a health benefits plan;

15 (2) refuse to pay a claim, cancel, or otherwise terminate a policy of life
16 insurance or health insurance or a health benefits plan;

17 (3) increase rates for life insurance, health insurance, or a health
18 benefits plan; or

19 (4) for policies of life insurance or health benefits plans, add a
20 surcharge, apply a rating factor, or use any other underwriting practice that adversely
21 takes the information into account.

22 (c) If an insurer acts in good faith, the insurer is not subject to tort liability
23 for a cause of action arising from the insurer’s lawful issuance of and lawful
24 compliance with a policy of life insurance on an insured who subsequently suffers
25 abuse or is a victim of domestic violence.

26 (d) This section does not require an insurer:

27 (1) to make a payment to an individual who willfully caused an injury
28 that gave rise to a loss under a policy of life insurance; or

29 (2) to issue, without the consent of the proposed insured, life insurance
30 or disability income insurance to an applicant known to have abused the proposed
31 insured.

32 (e) This section may not be interpreted to preclude an insurer **OR A HEALTH**
33 **MAINTENANCE ORGANIZATION** from using mental or physical medical conditions,

1 regardless of cause, in determining the eligibility, rate, or underwriting classification
2 of the applicant [or], insured, **MEMBER, OR SUBSCRIBER.**

3 27-606.

4 (a) (1) Except for life insurance, health insurance, and annuities, an
5 insurer that intends to cancel or not renew a line of business shall file a plan of
6 withdrawal with the Commissioner at least 180 days before the date of the proposed
7 withdrawal.

8 (2) Notwithstanding paragraph (1) of this subsection, the
9 Commissioner may allow an insurer to file a plan of withdrawal at least 60 days before
10 the date of proposed withdrawal if the Commissioner determines that compliance by
11 the insurer with paragraph (1) of this subsection may result in:

12 (i) the impairment of the insurer;

13 (ii) the loss of or substantial changes in applicable reinsurance;
14 or

15 (iii) significant financial losses to the insurer.

16 (3) For health insurance:

17 (i) an insurer that intends to cancel or not renew a health
18 insurance product, as defined by the Commissioner, for all of its covered insureds in
19 the State shall file a plan of withdrawal with the Commissioner at least 90 days before
20 the date of the proposed cancellation or nonrenewal; and

21 (ii) an insurer that intends to withdraw completely from the
22 health insurance market in the State by canceling or not renewing all of its health
23 insurance products in the State shall file a plan of withdrawal with the Commissioner
24 at least 180 days before the date of the proposed withdrawal.

25 (b) The plan of withdrawal shall contain:

26 (1) a statement by an elected officer of the insurer that the
27 cancellation or nonrenewal action is necessary as a result of:

28 (i) the loss of or substantial changes in applicable reinsurance;

29 (ii) financial losses of the insurer; or

30 (iii) another business or economic reason of the insurer;

31 (2) if the reason for cancellation or nonrenewal is loss of or substantial
32 changes in reinsurance, a statement that explains:

1 (i) that the insurer made a good faith effort to obtain
2 replacement reinsurance, but was unable to do so due to either the unavailability or
3 unaffordability of replacement reinsurance;

4 (ii) how the loss of or reduction in reinsurance affects the
5 insurer's risks throughout the entire line or category of insurance proposed for
6 cancellation or nonrenewal; and

7 (iii) why cancellation or nonrenewal is necessary to cure the loss
8 of or reduction in available reinsurance; and

9 (3) notwithstanding the reason for cancellation or nonrenewal, a
10 statement that:

11 (i) identifies the category of risk, the total number of risks
12 written by the insurer in that line of business, and the number of risks intended to be
13 canceled or not renewed;

14 (ii) explains how the cancellation or nonrenewals, if approved,
15 will be implemented with respect to individual risks and the steps that will be taken to
16 ensure that the cancellation or nonrenewal decisions will not be applied in an
17 arbitrary, capricious, or unfairly discriminatory manner or in violation of § 27-501 of
18 this title; and

19 (iii) includes any other information that the Commissioner
20 reasonably requires.

21 (c) If a plan of withdrawal filed with the Commissioner is not accompanied
22 by the information required by this section, the Commissioner may so inform the
23 insurer and the plan of withdrawal will be deemed filed when the information is
24 provided to the Commissioner.

25 (d) After an insurer has filed a plan of withdrawal with the Commissioner,
26 the insurer shall notify in writing each of its insurance producers in the State that the
27 insurer has filed a plan of withdrawal.

28 (e) The Commissioner shall review each plan of withdrawal to determine its
29 compliance with this section and § 27-501 of this title.

30 (f) (1) (i) The Commissioner shall disapprove each plan of withdrawal
31 that does not comply with this section.

32 (ii) If the Commissioner disapproves a plan, the Commissioner
33 shall issue an order of disapproval that includes specific reasons for the disapproval.

1 (2) (i) Subject to paragraph (3) of this subsection, a plan filed
2 under this section is deemed approved if the Commissioner fails to approve or
3 disapprove the plan within 60 days after the date of filing by the insurer.

4 (ii) If a filing is deemed approved under this paragraph, the
5 filing becomes effective on the 60th day after the date of filing.

6 (3) If the Commissioner does not have sufficient information to
7 determine whether a filing or amended filing meets the requirements of this section,
8 the Commissioner:

9 (i) shall require the insurer to provide the necessary
10 information; and

11 (ii) may extend the period for approval until the information is
12 provided.

13 (4) A plan may be withdrawn or amended by the insurer at any time
14 before approval.

15 (5) After approval or disapproval of a plan, the withdrawal or
16 amendment of the plan is subject to the approval of the Commissioner.

17 (g) The Commissioner may disapprove a plan of withdrawal for health
18 insurance if an insurer, nonprofit health service plan, or health maintenance
19 organization has failed to demonstrate compliance with § 15–1212 or § 15–1308 of this
20 article.

21 **(H) THE PROVISIONS OF SUBSECTIONS (A)(3) AND (B) THROUGH (F) OF**
22 **THIS SECTION THAT APPLY TO INSURERS ALSO APPLY TO HEALTH**
23 **MAINTENANCE ORGANIZATIONS.**

24 SECTION 3. AND BE IT FURTHER ENACTED, That it is the intent of the
25 General Assembly that this Act shall be construed as a nonsubstantive revision to
26 consolidate and clarify provisions of the insurance laws of the State that apply to
27 health maintenance organizations, and this Act may not be construed to make any
28 substantive change in the laws of the State.

29 SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect
30 June 1, 2014.