Chapter 355

(Senate Bill 893)

AN ACT concerning

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

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

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

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

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

Article – Health – General

19–706.

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

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

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

HG, § 19–706(h) is repealed in light of IN, § 15–401(b)(1)(iv) and (v), which, as enacted by Section 2 of this Act, provides that § 15–401(b) applies to each individual and group contract that provides certain coverage and is delivered, issued for delivery, or renewed in the State by an HMO; the inclusion of HMOs in the substantive provisions of IN, § 15–401(c), (d), (g), and (h), as enacted by Section 2 of this Act; IN, § 15–402(a)(2), which, as enacted by Section 2 of this Act, provides that IN, § 15–402 applies to each contract that is issued in the State by an HMO; IN, § 15–403(a)(4) and (5), which, as enacted by Section 2 of this Act, provides that § 15–403 applies to each individual and group contract that provides certain coverage and is issued by an HMO; the inclusion of HMOs in the substantive provisions of IN, § 15–403(c) and (d), as enacted by Section 2 of this Act; IN, § 15–403.1(a)(4) and (5), which, as enacted by Section 2 of this Act, provides that § 15–403.1 applies to each individual and group contract that provides certain coverage and is issued by an HMO; the inclusion of HMOs in the substantive provisions of IN, § 15–403.1(c) and (d), as enacted by Section 2 of this Act; IN, § 15–405(a)(2), which includes an HMO in the defined term "carrier" for purposes of § 15–405; and IN, § 15–405(b)(1), which provides that § 15–405 applies to HMOs.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

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

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

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

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

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

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

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

HG, § 19–706(s) is repealed in light of IN, § 15–1301(e), which includes an HMO in the defined term "carrier" for purposes of Title 15, Subtitle 13; IN, § 15–1301(l)(1),

which includes an HMO subscriber or group master contract in the defined term "health benefit plan" for purposes of Title 15, Subtitle 13; the inclusion of HMOs in the substantive provisions of IN, §§ 15–1308(g) and 15–1316(g); IN, § 15–1401(d), which includes an HMO in the defined term "carrier" for purposes of Title 15, Subtitle 14; IN, § 15–1401(j)(1), which includes an HMO subscriber or group master contract in the defined term "health benefit plan" for purposes of Title 15, Subtitle 14; the inclusion of HMOs in the substantive provisions of IN, §§ 15–1408(6) and 15–1409(d); IN, § 15–1501(a)(3)(i) which, as enacted by Section 2 of this Act, includes in the defined term "mandated health insurance service" a legislative proposal or statute that would require a particular health care service to be provided or offered in a health benefit plan by an HMO; and the inclusion of HMOs in the substantive provisions of IN, § 15–1501(c)(2)(iii)4, as enacted by Section 2 of this Act.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

The cross–reference to IN, Title 27, Subtitle 8 is retained in HG, § 19–706. Title 27, Subtitle 8 requires certain persons to report insurance fraud and an authorized insurer and a viatical settlement provider to have an insurance antifraud plan. There is no express reference to an HMO in Title 27, Subtitle 8, and it is unclear which provisions apply to HMOs, including whether an HMO's insurance antifraud plan would need to comply with the requirements applicable to authorized insurers, which differ from those applicable to viatical settlement providers. Since the application of the provisions of Title 27, Subtitle 8 to HMOs is unclear, the cross–reference is

retained to avoid any inadvertent substantive change in the application of State insurance laws to HMOs.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

The reference to IN, Title 15, Subtitles 10A, 10C, and 10D in HG, § 19–706(y) is repealed in light of IN, § 15–10A–01(c), which includes an HMO in the defined term "carrier" for purposes of Title 15, Subtitle 10A; the inclusion of HMOs in the substantive provisions of IN, § 15–10A–04(c)(2) and (3); IN, § 15–10C–01(f)(1), which defines a "medical director" to mean a physician employed by or under contract with an HMO to perform specified duties related to quality assurance and utilization management; the inclusion of HMOs in the substantive provisions of IN, §§ 15–10C–03(b)(2) and 15–10C–04(a); IN, § 15–10D–01(d), which includes an HMO in the defined term "carrier" and § 15–10D–01(h)(i)(iii), which includes an HMO contract in the defined term "health benefit plan", for purposes of Title 15, Subtitle 10D; and the inclusion of HMOs in the substantive provisions of IN, §§ 15–10D–02(e)(1) and 15–10D–03(b)(2)(ii).

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

Note that the application of all provisions of IN, § 15–833 to HMOs under HG, § 19–706(hh) is overly broad in that § 15–833(g) applies to policies that limit coverage to

hospital or surgical benefits and hospital indemnity policies, and § 15–833(i) applies to insurers that provide accidental death or dismemberment benefits.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

HG, § 19–706(ww) is repealed in light of the inclusion of HMOs in the substantive provisions of IN, § 27–606(g) and IN, § 27–606(h) which, as enacted by Section 2 of this Act, provides that the provisions of § 27–606(a)(3) and (b) through (f) that apply to insurers also apply to HMOs.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

HG, § 19–706(hhh) applies the provisions of IN, § 27–222 to HMOs. IN, § 27–222 prohibits a person from violating IN, § 15–112(l). HG, § 19–706(hhh) is

repealed in light of IN, § 15–112(a)(4)(i), which includes an HMO in the definition of "carrier" for purposes of § 15–112.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

[(nnn)**]** **(I)** The provisions of § 15–145 of this article apply to health maintenance organizations.

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

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

DRAFTER'S NOTE:

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

[(mmmm) The provisions of § 15–139 of the Insurance Article apply to health maintenance organizations.**]**

DRAFTER'S NOTE:

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

[(nnnn) The provisions of § 15–135.1 of the Insurance Article apply to health maintenance organizations.**]**

DRAFTER'S NOTE:

HG, § 19–706(nnnn) is repealed in light of IN, § 15–135.1(a)(2), which includes an HMO in the defined term "carrier" for purposes of § 15–135.1.

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

Article – Insurance

2–112.

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

(1) fees for certificates of authority:

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

(ii) fee for initial certificate of authority..... $200

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

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

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

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

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

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

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

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

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

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

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

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

(4) fees for certificates of qualification:

(i) application fee $25

(ii) managing general agent certificate of qualification:

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

2. annual renewal fee..... $30

(iii) surplus lines broker certificate of qualification:

1. fee for initial certificate within 1 year of renewal.....$100

2. fee for initial certificate over 1 year from renewal.....$100

3. biennial renewal fee $200

(5) fee for temporary insurance producer licenses and appointments.....$27

(6) fees for licenses:

(i) public adjuster license:

1. fee for initial license within 1 year of renewal..... $25

2. fee for initial license over 1 year from renewal..... $50

3. biennial renewal fee $50

(ii) adviser license:

1. fee for initial license within 1 year of renewal..... $100

2. fee for initial license over 1 year from renewal..... $200

3. biennial renewal fee $200

(iii) insurance producer license:

1. fee for initial license $54

2. biennial renewal fee $54

(iv) SHOP Exchange navigator license:

1. fee for initial license $54

2. biennial renewal fee $54

3. fee for reinstatement of license..... $100

(v) application fee $25

(7) fee for each insurance vending machine license, for each machine, every second year.....$50

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

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

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

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

5–608.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. possession of the acceptable collateral;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102% of the purchase price.

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

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

15–118.

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

(2) "Health care service" means a health or medical care procedure or service rendered by a provider that:

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

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

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

(b) This section applies to**:**

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

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

(c) If an entity subject to this section negotiates and enters into a contract with providers to render health care services to insureds**, SUBSCRIBERS, OR MEMBERS** at alternative rates of payment, and coinsurance payments are to be based on a percentage of the fee for health care services rendered by a provider, the entity shall calculate the amount of the coinsurance payment to be paid by the insured**,**

SUBSCRIBER, OR MEMBER exclusively from the negotiated alternative rate for the health care service rendered.

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

15–401.

(a) In this section, "date of adoption" means the earlier of:

(1) a judicial decree of adoption; or

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

(b) (1) This subsection applies to:

(i) each individual health insurance policy that:

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

2. provides coverage on an expense–incurred basis; and

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

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

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

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

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

(iii) each individual service or indemnity contract that:

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

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

(IV) EACH INDIVIDUAL CONTRACT THAT:

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

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

(V) EACH GROUP CONTRACT THAT:

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

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

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

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

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

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

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

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

(1) provide notice to the policyholder **OR CONTRACT HOLDER** that coverage for a newly born or newly adopted child or grandchild or a minor for whom

guardianship is granted by court or testamentary appointment is not provided under the policy **OR CONTRACT**; and

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

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

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

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

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

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

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

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

15–402.

(a) This section applies to:

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

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

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

(i) is unmarried;

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

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

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

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

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

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

15–403.

(a) This section applies to:

(1) each individual health insurance policy that:

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

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

(2) each group health insurance policy that:

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

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

(3) each individual service or indemnity contract that:

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

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

(4) EACH INDIVIDUAL CONTRACT THAT:

(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION; AND

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

(5) EACH GROUP CONTRACT THAT:

(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;

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

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

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

(1) is unmarried;

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

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

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

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

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

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

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

15–403.1.

(a) This section applies to:

(1) each individual health insurance policy that:

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

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

(2) each group health insurance policy that:

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

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

(3) each individual service or indemnity contract that:

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

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

(4) EACH INDIVIDUAL CONTRACT THAT:

(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION; AND

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

(5) EACH GROUP CONTRACT THAT:

(I) IS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION;

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

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

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

(1) is unmarried;

(2) is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, of the insured, subscriber, employee, or member;

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

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

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

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

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

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

15–803.

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

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

15–818.

(a) This section applies to:

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

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

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

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

15–823.

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

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

(3) "Qualified individual" means:

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

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

(iii) an individual receiving long–term glucocorticoid (steroid) therapy;

(iv) an individual with primary hyperparathyroidism; or

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

(b) This section applies to:

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

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

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

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

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

15–903.

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

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

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

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

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

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

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

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

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

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

15–1501.

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

(2) "Commission" means the Maryland Health Care Commission.

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

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

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

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

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

(i) social impacts, including:

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

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

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

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

5. the level of public demand for the service;

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

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

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

(ii) medical impacts, including:

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

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

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

(iii) financial impacts, including:

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

2. the extent to which the coverage will increase the appropriate use of the service;

3. the extent to which the mandated service will be a substitute for a more expensive service;

4. the extent to which the coverage will increase or decrease the administrative expenses of **[**insurers**]** **CARRIERS, INCLUDING HEALTH MAINTENANCE ORGANIZATIONS, OR OTHER ORGANIZATIONS AUTHORIZED TO PROVIDE HEALTH BENEFIT PLANS IN THE STATE,** and the premium and administrative expenses of policy holders **AND CONTRACT HOLDERS**;

5. the impact of this coverage on the total cost of health care; and

6. the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

(d) Subject to the limitations of the State budget, the Commission may contract for actuarial services and other professional services to carry out the provisions of this section.

(e) (1) On or before December 31, 1998, and each December 31 thereafter, the Commission shall submit a report on its findings, including any recommendations, to the Governor and, subject to § 2–1246 of the State Government Article, the General Assembly.

(2) The annual report prepared by the Commission shall include an evaluation of any mandated health insurance service legislatively proposed or otherwise submitted to the Commission by a member of the General Assembly prior to July 1 of that year.

27–209.

Except as otherwise expressly provided by law, a person**, INCLUDING A HEALTH MAINTENANCE ORGANIZATION,** may not knowingly:

(1) allow, make, or offer to make a contract of life insurance or health insurance or an annuity contract or an agreement as to the contract other than as plainly expressed in the contract;

(2) pay, allow, give, or offer to pay, allow, or give directly or indirectly as an inducement to the insurance or annuity:

(i) a rebate of premiums payable on the contract;

(ii) a special favor or advantage in the dividends or other benefits under the contract;

(iii) paid employment or a contract for services of any kind; or

(iv) any valuable consideration or other inducement not specified in the contract;

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

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

27–302.

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

(1) is delivered or issued in the State;

(2) is issued to a group that has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) This subtitle does not apply to:

(1) reinsurance;

(2) workers' compensation insurance; or

(3) surety insurance.

27–303.

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

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

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

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

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

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

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim;

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

(8) fail to comply with the provisions of Title 15, Subtitle 10A of this article;

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

(10) fail to comply with the provisions of § 16–118 of this article.

27–304.

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

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) fail to acknowledge and act with reasonable promptness on communications about claims that arise under policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims that arise under policies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27–305.

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

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

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

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

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

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

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

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

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

27–504.

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

(2) "Abuse" has the meaning stated in § 4–501 of the Family Law Article.

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

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

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

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

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

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

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

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

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

(c) If an insurer acts in good faith, the insurer is not subject to tort liability for a cause of action arising from the insurer's lawful issuance of and lawful

compliance with a policy of life insurance on an insured who subsequently suffers abuse or is a victim of domestic violence.

(d) This section does not require an insurer:

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

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

(e) This section may not be interpreted to preclude an insurer **OR A HEALTH MAINTENANCE ORGANIZATION** from using mental or physical medical conditions, regardless of cause, in determining the eligibility, rate, or underwriting classification of the applicant **[**or**],** insured**, MEMBER, OR SUBSCRIBER**.

27–606.

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

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

(i) the impairment of the insurer;

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

(iii) significant financial losses to the insurer.

(3) For health insurance:

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

(ii) an insurer that intends to withdraw completely from the health insurance market in the State by canceling or not renewing all of its health

insurance products in the State shall file a plan of withdrawal with the Commissioner at least 180 days before the date of the proposed withdrawal.

(b) The plan of withdrawal shall contain:

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

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

(ii) financial losses of the insurer; or

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

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

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

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

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

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

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

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

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

(c) If a plan of withdrawal filed with the Commissioner is not accompanied by the information required by this section, the Commissioner may so inform the

insurer and the plan of withdrawal will be deemed filed when the information is provided to the Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Approved by the Governor, May 5, 2014.