SB 893

Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 893 (Senator Charles)
Finance

Insurance - Enforcement, Impaired Entities, Homeowner's Insurance Policies, and Unfair Claim Settlement Practices - Revisions

This bill significantly expands the regulatory responsibilities of the Maryland Insurance Administration (MIA) and various requirements for insurers who do business in the State. Notably, and among other things, the bill affects MIA's enforcement authority, modifies the process and timeframes for examinations of insurers conducted by MIA, and establishes new requirements and prohibitions for homeowner's insurers and other insurers.

Fiscal Summary

State Effect: Special fund expenditures for MIA increase by $9.5 million in FY 2026 for additional staff and contractual resources. Future years reflect annualization, inflation, and elimination of one-time costs. Special fund revenues for MIA increase by $5.9 million in FY 2026 and $8.3 million annually thereafter under the assumptions discussed below.

($ in millions)	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
SF Revenue	$5.9	$8.3	$8.3	$8.3	$8.3
SF Expenditure	$9.5	$12.6	$12.8	$13.0	$13.2
Net Effect	($3.6)	($4.3)	($4.5)	($4.7)	($4.9)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: Broadly speaking, the bill:

- establishes a framework for determining if an insurer, after an examination, should be subject to enhanced enforcement penalties;

- requires the Insurance Commissioner to establish a risk-based methodology for examining certain insurers;
- requires insurers determined to be high-risk insurers to be examined by MIA every three years instead of every five years;
- specifies the circumstances under which homeowner's insurers either may or must be subject to an additional market conduct examination by MIA;
- requires MIA to submit to the General Assembly various quarterly and annual reports;
- requires the Office of the Attorney General (OAG) to provide specified information to the Fraud Division of MIA when it does not prosecute a referred case;
- includes additional factors the Commissioner may consider when determining whether an insurer is considered hazardous;
- establishes new responsibilities for MIA and homeowner's insurers related to premium discounts;
- establishes new requirements for homeowner's insurers related to the temporary suspension of writing new insurance policies;
- requires homeowner's insurers to create and use claims-handling manuals; and
- prohibits homeowner's insurers and other insurers from taking certain actions.

The following sections include a more detailed discussion of each of the bill's changes.

Determination of Enhanced Enforcement Penalties for Insurers

The bill authorizes the Commissioner to determine if an insurer should be subject to enhanced enforcement penalties, as specified, if the Commissioner finds a pattern or practice of the insurer failing to take the following actions when responding to covered claims under an insurance policy, after receiving actual notice, as defined by the bill, of the claims:

- assign a licensed and appointed insurance adjuster to investigate whether coverage is provided under the policy and diligently attempt to resolve any question concerning the extent of the insured's coverage;
- evaluate the claim fairly, honestly, and with due regard for the interest of the insured, based on available information;
- request from the insured or claimant additional relevant information the insurer reasonably determines is necessary to evaluate whether to settle a claim;
- conduct all oral and written communications with the insured with honesty and candor;

- make reasonable efforts to explain to individuals not represented by counsel matters requiring expertise beyond the level normally expected of a layperson with no training in insurance or claims-handling issues;
- retain all written and recorded communications and create and retain a summary of all verbal communications in a reasonable manner for at least two years after the entry of a final judgment against the insured in excess of policy limits or, if any extracontractual claim is made, the conclusion of the claim and any related appeals, whichever is later;
- within 30 days after the date of a request, provide the insured with all communications related to the insurer's handling of the claim that are not privileged as to the insured;
- provide, on request and at the insurer's expense, reasonable accommodations necessary to communicate effectively with an insured covered under the federal Americans with Disabilities Act;
- when handling a third-party claim, communicate specified information with the insured;
- respond to any requests for insurance information;
- seek to obtain a general release of each insured in making any settlement offers to a third-party claimant;
- take reasonable measures to preserve any documentary, photographic, and forensic evidence as needed for the defense of the liability claim if it appears likely that the insured's liability exposure is greater than the policy limits and the insurer fails to secure a general release in favor of the insured;
- comply with current law regarding the examination of insurers; or
- comply with Title 27 of the Insurance Article, which governs unfair and otherwise prohibited practices.

The bill further specifies that, when MIA reviews an insurer's claims handling practices, it is relevant whether the insured, the claimant, or a representative of the insured or claimant was acting reasonably toward the insurer in furnishing information regarding the claim, making demands of the insurer, setting deadlines, and attempting to settle the claim, including whether:

- the insured cooperated with the insurer in the defense of the claim and in making settlements by taking reasonable actions requested by the claimant or required by the policy that are necessary to assist the insurer in settling a covered claim, as specified; and
- the claimant and the claimant's representative, if any, (1) acted honestly in furnishing information regarding the claim; (2) acted reasonably in setting

deadlines; and (3) refrained from taking actions that may be reasonably expected to prevent an insurer from accepting the settlement demand, as specified.

These requirements may not be construed to create a civil cause of action or a civil remedy or constitute a violation of Title 27 of the Insurance Article.

Risk-based Selection Methodology for Examining Insurers

The Commissioner must adopt rules to develop a risk-based selection methodology, as specified, for scheduling its ongoing examinations of insurers. The rules must include (1) the use of a risk-focused analysis to prioritize financial examinations of insurers if reporting indicates a decline in the insurer's financial condition; (2) consideration of specified factors; (3) prioritization of insurers issuing, selling, or delivering homeowner's insurance policies in the State for which the Commissioner identifies significant concerns about an insurer's solvency; and (4) any other matters the Commissioner determines necessary to consider for the protection of the public.

Instead of examining each insurer at least once every five years, the bill requires the Commissioner to examine each high-risk insurer at least once every three years. Each average and low-risk insurer continues to be subject to examination at least once every five years.

Market Conduct Examinations for Homeowner's Insurers

The bill specifies that, after a hurricane, an insurer issuing, selling, or delivering homeowner's insurance policies in the State *may* be subject to an additional market conduct examination if, at any time more than 90 days after the end of the hurricane, the insurer is among the top 20% of insurers based on a calculation of the ratio of the hurricane-related property claims filed to the number of property insurance policies in force. However, a homeowner's insurer *must* be subject to an additional market conduct examination if at any time more than 90 days after the end of a hurricane, the insurer:

- is among the top 20% of insurers based on a calculation of the ratio of hurricane claim-related consumer complaints made to the Commissioner to the insurer's total number of hurricane-related claims;
- is among the top 20% of insurers based on a calculation of the ratio of hurricane claims closed without payment to the insurer's total number of hurricane claims on policies providing wind or windstorm coverage; or
- has made significant payments to its managing general agent since the hurricane.

The additional market conduct examination, whether required or optional, must be initiated within 18 months after the date of landfall of a hurricane that results in an executive order

or state of emergency issued by the Governor and include an examination of the insurer's managing general agent. The Commissioner is not required to conduct multiple examinations of the same insurer in the event multiple hurricanes make landfall in the State in a single calendar year.

Other Timing Considerations Related to Examinations

The Commissioner must adopt regulations to establish a selection methodology for scheduling and conducting market conduct examinations that prioritize the examination of entities meeting specified criteria. Examinations conducted by MIA and the Commissioner must cover (1) for low-risk insurers, at least the immediately preceding five fiscal years and (2) for average- and high-risk insurers, the fiscal years since the last examination.

The provisions of the bill relating to market conduct and other such examinations do not restrict the Commissioners authority to conduct examinations when it would otherwise be advisable to do so.

Quarterly and Annual Reports to the General Assembly

The Commissioner must submit a quarterly report to specified committees of the General Assembly detailing (1) the actions the Commissioner has taken to enforce compliance with the Insurance Article, as specified; (2) the revocation, denial, or suspension of a license issued under the Insurance Article; (3) the actions taken related to the Commissioner's authorized enforcement powers; (4) the fines imposed for violations of the Insurance Article; (5) the consent orders the Commissioner has entered into; (6) the examinations and investigations conducted; and (7) the investigations conducted under and completed where a violation was discovered but no action was taken.

In addition to the quarterly reports, the Commissioner must submit an annual report, no later than December 31 of each year, to specified committees of the General Assembly that includes the information required in the quarterly report for the immediately preceding calendar year. The Commissioner may exclude information that would violate a confidentiality provision included in any agreement, order, or consent order the Commissioner enters. The Fraud Division of MIA must also submit an annual report, by December 1 each year, to the General Assembly on:

- specified indicators related to, among other things, referrals received and made, cases referred and closed, and investigations undertaken by the Fraud Division;
- the total number of employees assigned to the Fraud Division delineated by the location of staff assigned and the number and location of employees assigned to investigate other types of fraud cases;

- the average caseload and turnaround, by case type, for each investigator assigned to the Fraud Division; and
- the training provided to investigators assigned to the Fraud Division during the period covered by the repot.

Office of the Attorney General Report to the Fraud Division

Instead of reporting to MIA on each case not prosecuted and the reasons why the case was not prosecuted, the bill requires OAG to report to the Fraud Division on each case:

- not prosecuted within 60 days after the date of referral by the Fraud Division and the reasons why the case was not prosecuted within 60 days of the referral; and
- if OAG or the State's Attorney declined to prosecute a case and the reasons why.

Insurer Hazard Determinations

The bill adds 10 additional factors that the Commissioner may consider when determining whether the continued operation of an insurer in the State would be hazardous to policyholders or creditors of the insurer, or the public generally. Among other things, in making the determination, the commission may consider whether (1) the insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law; (2) the insurer continues to write new business when it has not maintained the required surplus or capital; and (3) the insurer has incurred substantial new debt, has had to rely on frequent or substantial capital infusions, or has a highly leveraged balance sheet.

Discounts by Homeowner's Insurers

Each homeowner's insurer that offers a premium discount must provide information describing the availability of the discounts it offers, accessible on the primary page of the insurer's website.

Beginning October 1, 2030, and every five years thereafter, the Commissioner must evaluate and update the fixtures or construction techniques demonstrated to reduce the amount of loss in a hurricane or other storm and the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of the fixtures or construction techniques.

Temporary Suspension of Writing New Homeowner's Insurance Policies

Except under specified circumstances, before *temporarily* suspending its writing of new homeowner's insurance policies in the State, an insurer must give *notice* to the Commissioner of the insurer's reason for the action, the effective dates of the temporary

suspension, and the proposed communication to its agents. The notice must be provided on a form approved by the Commissioner and submitted to the Commissioner within a specified timeframe. An insurer must provide to the Commissioner any other information relating to the suspension requested by the Commissioner. The Commissioner may adopt regulations to implement this requirement.

However, an insurer need not obtain *approval* from the Commissioner before temporarily suspending its writing of new homeowner's insurance policies in the State.

Claims-handling Manuals Required for Homeowner's Insurers

Authorized insurers of homeowner's insurance policies in the State must create and use a claims-handling manual with guidelines and procedures that comply with State law and standard industry practice. The manual must include specified guidelines for, among other things, initially receiving a claim, investigating the claim, and closing a claim. The Commissioner may, at any time, request an authorized insurer to submit a physical or electronic copy of the insurer's currently applicable, or otherwise specifically requested, claims-handling manual. The bill establishes the process and timeframe by which an insurer must reply to the request.

Each year, an authorized homeowner's insurer must certify and attest, as specified, that each of its current claims-handling manuals complies with the minimum standards set forth in the bill. The insurer must also certify and attest that it has adequate resources available to implement the requirements of each of its claims-handling manuals at all times, including during natural disasters and catastrophic events.

The Commissioner may adopt regulations to implement these requirements.

Repaired Structures

An authorized homeowner's insurer may not cancel or refuse to renew a homeowner's insurance policy if (1) the property has been damaged as a result of a hurricane or wind loss that is the subject of a declaration of a state of emergency and the filing of an order by the Commissioner, for a period of 90 days after the date on which the property is deemed repaired or (2) the aforementioned circumstance does not apply and the property was damaged by a covered peril until the property is deemed repaired or one year after the insurer issues a final claim payment, whichever is earlier. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another insurer writing policies in the State.

Unfair Claim Settlement Practices

The bill specifies that it is considered an unfair claim settlement practice and, therefore, unlawful for an insurer, nonprofit health service plan, or health maintenance organization (HMO) to alter or amend an insurance adjuster's report without providing a detailed explanation as to why a change that has the effect of reducing the estimate of the loss was made. For any such changes, additional information must also *either* be included in the report (or as an addendum to the report) *or* retained – specifically, a detailed list of all changes made and the identity of the individual who ordered each change *or* retention of all versions of the report, including the identity of each individual who ordered each change within each version.

Current Law:

Maryland Insurance Administration – Generally

MIA and the Insurance Commissioners' statutory and regulatory duties include, among other things, certifying insurers to operate in the State, reviewing and approving the rates and forms used by insurers, and licensing and certifying insurance professionals. MIA and the Commissioner have broad authority to enforce the requirements and prohibitions that apply to insurers and insurance professionals. For example, depending on the type of violation and following the administrative processes required by Insurance Law and regulations, the Commissioner is authorized to issue orders directing insurers or insurance professionals to take certain actions, impose administrative penalties, and suspend or revoke certifications and/or licenses. To accomplish its statutory duties, MIA is organized into a number of sections, divisions, and units, which each handle a specific aspect of insurance regulation.

There are 53 domestic insurance companies and approximately 1,500 foreign *(i.e.*, nondomestic) insurance companies operating in Maryland. MIA is required to monitor the financial condition of domestic insurers on an ongoing basis (by analyzing various periodic financial reports) and to conduct a comprehensive financial examination of each domestic insurer at least once every five years. Since 1990, the National Association of Insurance Commissioners (NAIC) has administered the Financial Regulation Standards and Accreditation Program. To attain and maintain NAIC accreditation, a state must adopt and demonstrate effective implementation of NAIC's framework for the financial regulation of insurance companies. All 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are currently accredited by NAIC. The State can (and currently does) rely on the domiciliary state of a foreign insurance company to monitor the company's financial condition.

Maryland Insurance Administration – Insurance Fraud Division

In 1992, the Insurance Fraud Division was established by the Governor as a unit within the Department of Licensing and Regulation (Executive Order 01.01.1992.24). The unit transferred to the Office of the Governor in 1993 (Chapter 538 1993; Executive Order 01.01.1994.16). In July 1995, the unit joined MIA. Cooperating with the Department of State Police and OAG, the division investigates and prosecutes individuals and companies who commit insurance fraud. In addition, the division reviews anti-fraud plans and annual fraud statistics submitted by insurance companies.

Notably, OAG must report to the Fraud Division on each case not prosecuted and the reasons why the case was not prosecuted.

Examination of Insurers

When the Insurance Commissioner considers it advisable, the Commissioner must examine the affairs, transactions, accounts, records, and assets of each authorized insurer, insurer management company, subsidiary owned or controlled by an authorized insurer, rating organization, or authorized HMO. The Commissioner is required to examine each domestic insurer and HMO at least once every five years. The Commissioner is also required to examine an insurer, HMO, or rating organization that applies for a certificate of authority or license.

Determination of a Financially Hazardous Insurer

The Commissioner is authorized to review an authorized insurer operating in the State to determine if their continued operation would be hazardous for policyholders or creditors of the insurer or the general public. Among other things, the Commissioner is authorized to consider adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinion, reports, or summaries.

Should the Commissioner determine that an insurer poses a hazard to the policyholders or creditors of the insurer or the general public, the Commissioner may require the insurer to, among other things:

- provide a business plan to the Commissioner in order to continue to transact business in the State;
- file reports in a form acceptable to the Commissioner about the market value of its assets; and
- reduce the total amount of present and potential liability for benefits under policies through reinsurance.

Unfair Trade Practices

The Insurance Article expressly prohibits certain insurer practices and activities as unfair trade practices. One such practice is that, with respect to any type of insurance, an insurer may not cancel or refuse to provide or renew coverage for a reason based wholly or partly on race, color, creed, sex, or blindness of an applicant or policyholder or for any arbitrary capricious, or unfairly discriminatory reason.

Premium Discounts

An insurer in the State must offer at least one actuarially justified premium discount on a policy of homeowner's insurance to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm.

State Fiscal Effect: Given the significant new and ongoing responsibilities for MIA established in the bill, MIA anticipates a significant operational and financial impact from implementation. Among other things, the bill creates the need for several new positions to develop and implement a new methodology for "risk-focused" financial analysis of insurance companies operating in Maryland, conduct financial examinations of a domestic or foreign insurer deemed to be "high risk" on a more frequent basis than currently occurs (at least once every three years) – with MIA also now assuming responsibility for conducting the examinations of foreign insurers, and investigate complaints pertaining to claims under a homeowner's policy to ascertain whether companies are handling claims in accordance with their manuals. Additionally, new staff is required to accomplish new responsibilities that have generally not been a component of MIA's regulatory work, such as reporting on storm-resistant construction methods or reviewing claims-handling manuals, as specified in the bill.

Therefore, special fund expenditures for MIA increase by $9.5 million in fiscal 2026, which accounts for the bill's October 1, 2025 effective date. This estimate reflects the cost of hiring 39 new employees to handle the substantial new regulatory responsibilities established by the bill. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. It also includes $5.9 million for contractual examination costs.

Positions	39.0
Salaries and Fringe Benefits	$3,348,438
Contractual Examination Services	5,850,000
Operating Expenses	287,381
Total FY 2026 State Expenditures	**$9,485,819**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Regarding the contractual examination costs, MIA advises that it uses consultants to assist in conducting financial examinations. MIA advises it currently has two contracts (both for five-year terms) in place with consulting firms for examination support services. The total amount awarded for these two contracts is $13.0 million. MIA estimates that, to implement the bill, it needs to secure additional examination support services at an estimated cost of $39.0 million over a five-year period (estimated at $5.9 million in fiscal 2026 and $8.3 million annually thereafter due to the bill's October 1, 2025 effective date).

Generally, MIA requires insurers to pay the costs associated with these examinations; therefore, this analysis assumes that the examination costs associated with the consultants are fully offset by special fund revenues. However, MIA advises it may have to absorb a portion of those costs and, in such a case, the increase in special fund revenues is less pronounced as fewer revenues are collected from insurers. The costs associated with the new staff are assumed to be covered with *existing* special fund revenues; nevertheless, to the extent some portion of those costs may also be recovered through charges to insurers, additional special fund revenues are realized.

This analysis does not include any revenues from rate and form filing fees that may be collected by MIA as a result of the bill. However, any such impact is anticipated to be minimal and MIA can review any such filings using existing budgeted resources. Additionally, the analysis does not include any potential impact on premium tax revenues as any such impact cannot be reliably estimated without actual experience under the bill.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

Information Source(s): Judiciary (Administrative Office of the Courts); Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 5, 2025
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