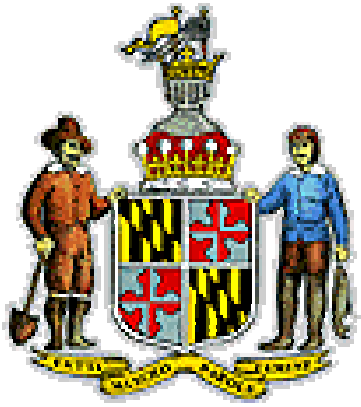
Maryland Insurance Administration



FY2002 and FY2003 Annual Report

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lieutenant Governor

Alfred W. Redmer, Jr.
Commissioner

James V. McMahan, III
Deputy Commissioner

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I. Overview: Maryland Insurance Administration

The **Maryland Insurance Administration** (MIA) began in 1872 as the Insurance Department under the Comptroller of the Treasury. In 1878 it became an independent agency and was renamed the State Insurance Department, a title it held for 92 years. In 1970, the Insurance Department moved to the Department of Labor, Licensing and Regulation and was renamed the Insurance Division. Reorganized as the Maryland Insurance Administration in 1993, today it is the independent State agency that regulates Maryland's insurance industry and protects consumers by ensuring that insurance companies and health plans act in accordance with the State's insurance law. The MIA licenses insurance companies, agents, and brokers operating in Maryland, conducts financial examinations of companies to ensure solvency, investigates insurance fraud, reviews and approves rates and contract forms, and conducts market conduct examinations of companies to ensure compliance with Maryland law. Consumers can contact the MIA when they have Life, Health, Automobile, Homeowners, or Property insurance complaints or inquiries. As designated by State law, the MIA is also the agency consumers can turn to to file health insurance appeals or grievances concerning coverage decisions or claims denials.

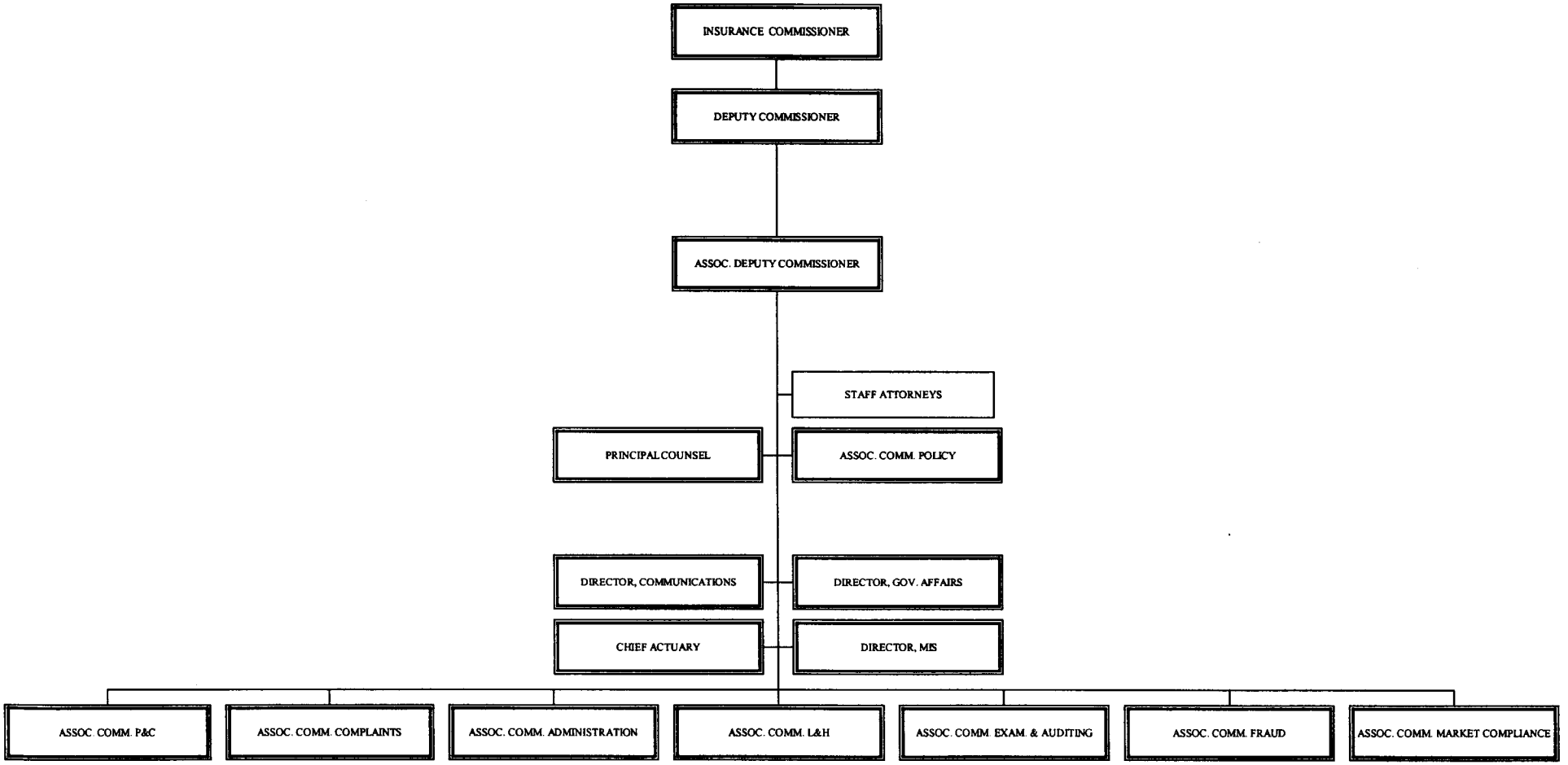
The current Insurance Commissioner is Alfred W. Redmer, Jr. He was appointed by Governor Robert L. Ehrlich, Jr., for a four year term running June 1, 2003 through May 31, 2007. During FY 2002 and FY 2003, the Insurance Commissioner was Steven B. Larsen.

MARYLAND INSURANCE ADMINISTRATION
Organizational Listing

Office of the Commissioner	2002	2003
Commissioner	Steven B. Larsen	Steven B. Larsen
Deputy Commissioner	Donna B. Imhoff	Donna B. Imhoff
Associate Deputy Commissioner	Thomas P. Raimondi	Thomas P. Raimondi
Director of Policy	Alexandra Thomas	Alexandra Thomas
Director of Govt. Affairs	Kathleen Loughran	Kathleen Loughran
Director of Communications	Debbie R. McKerrow	Debbie R. McKerrow
Office of the Attorney General		
Principal Counsel	Christina Beusch	Kathleen Birrane
Deputy Counsel	Dorothy Wilson	Randolph Sergent
Assistant Attorney General	Gary Alexander	Gary Alexander
Assistant Attorney General	Melinda Kimmitt	Melinda Kimmitt
Assistant Attorney General	Susan Cohen	Susan Cohen
Assistant Attorney General	Erik Delfosse	Erik Delfosse
Assistant Attorney General	Aretha Ector	Aretha Ector
Assistant Attorney General	Lisa Hall	Lisa Hall
Assistant Attorney General	Roberto Veloso	Roberto Veloso
Office of the Chief Actuary		
Chief Actuary	Donald Brandenberg	Donald Brandenberg
Rates-Life/Health	Elizabeth Hale	Elizabeth Hale
Examination-Life/Health	Robert Katz	Robert Katz
Management Information Systems (MIS)		
Director	Ronald Anderson	Ronald Anderson
Supervisor, Network Administration	Robert Dean	Robert Dean
Examination and Auditing Section		
Associate Commissioner	Lester C. Schott	Lester C. Schott
Chief Financial Analyst	Neil A. Miller	Neil A. Miller
Chief Insurance Examiner	Sean O'Donnell	Sean O'Donnell
Company Licensing	Chineta Alford	Chineta Alford
Consumer Complaints Investigation Section		
Associate Commissioner	Joy Y. Hatchette	Joy Y. Hatchette
Chief, L/H Inquiry & Investigation	Richard Pyle	Richard Pyle
Chief, P/C Inquiry & Investigation	Sandra Castagna	Sandra Castagna
Chief, Appeals & Grievance Unit	Louis Butler, Jr.	Louis Butler, Jr.

Life and Health Section	**2002**	**2003**
Associate Commissioner	Wendy Taparanskas	Howard Max, acting
Chief Administrator	Howard Max	Howard Max
Chief of Managed Care	Brenda Wilson	Brenda Wilson
Managed Care Coordinator	Thomas Marshall	(moved below)
Chief Market Conduct Examiner	Todd Cioni	(moved below
Chief, Agent Enforcement Unit	John H. Riggle	(moved below)
Chief, PRA/Medical Review Unit	Ellen Woodall	Ellen Woodall
Property and Casualty Section		
Associate Commissioner	Robert J. Becker	vacant
Chief Administrator	David Diehl	David Diehl
Chief Market Conduct Examiner	Dudley Ewen	(moved below)
Chief Agent Enforcement Unit	Tobie Jacobs	(moved below)
Chief Rates and Forms Unit	Fred Santiago	Fred Santiago
Actuaries	Alan Clark	Alan Clark
	Linas Glemza	Linas Glemza
Compliance and Enforcement Section (FY 2003)		
Associate Commissioner……		Todd Cioni
Chief L&H Market Conduct Examiner……..		Leighton Tabron
Chief Agent Enforcement……		John Riggle
Chief P&C Market Conduct Examiner……....		Dudley B. Ewen
Administration		
Associate Commissioner Administration	Nikhil M. Divecha	Nikhil M. Divecha
Associate Commissioner……	Lorenza Trotter	Lorenza Trotter
Manager, Producer Licensing	Jean E. Bienemann	Jean E. Bienemann
Director of Personnel	Norval E. Byrd	Norval E. Byrd
Director, Fiscal Services	Ilene M. Carroll	Charles Spannare
Director of Training & Facilities Mgt	John Dahne	John Dahne
Insurance Fraud Division		
Associate Commissioner……	Ronald Sallow	Ronald Sallow
Chief Investigator……...	William Bokel	William Bokel
Assistant Attorney General……	Richard Bernhardt	Richard Bernhardt
Assistant Attorney General……	Emmet Davitt	Emmet Davitt
Assistant Attorney General……	Bernard Taylor	Bernard Taylor
Md. State Police…….	Cpl. Steven Sugg	Cpl. Steven Sugg
Maryland Health Insurance Plan (Created July 1, 2002)		
Director……..		Richard Popper

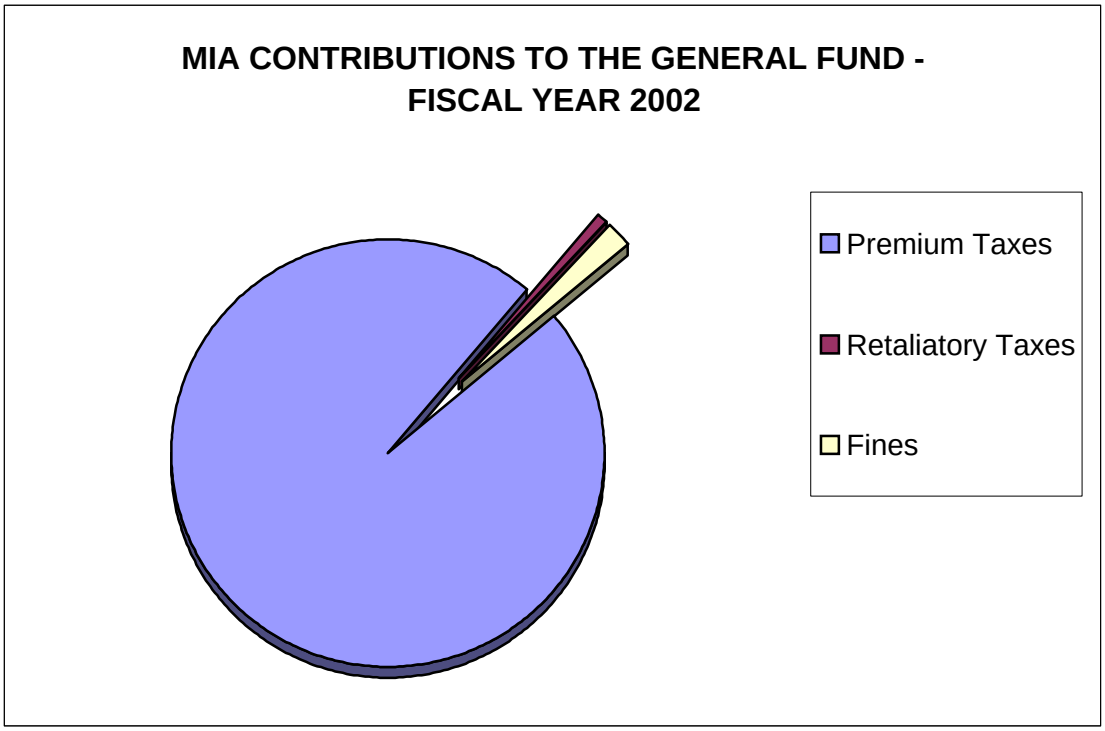
MARYLAND INSURANCE ADMINISTRATION



Fiscal Information FY2002

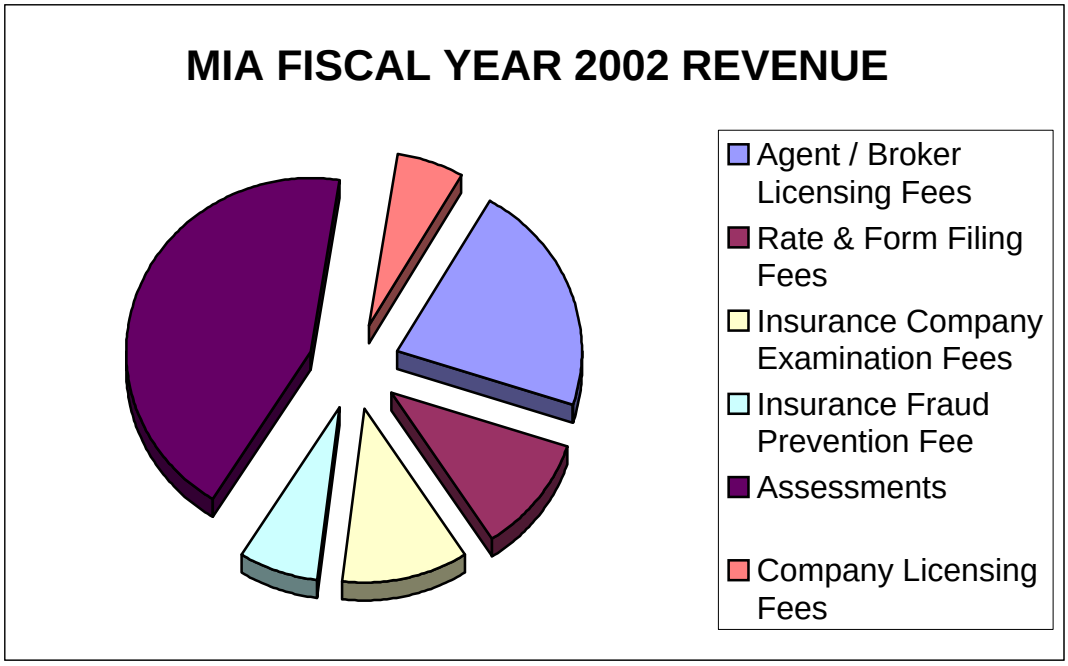
MIA CONTRIBUTIONS TO THE GENERAL FUND - FISCAL YEAR 2002

Premium Taxes	$ 191,204,876
Retaliatory Taxes	1,783,315
Fines	3,774,431
	196,762,622



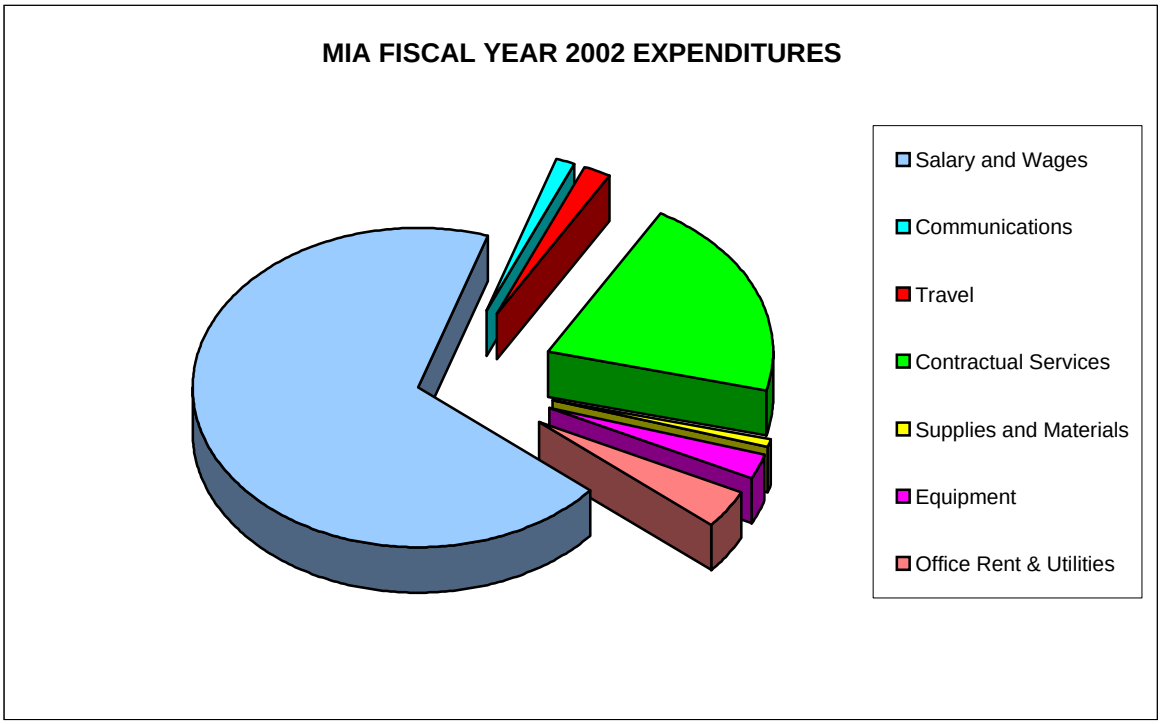
MIA FISCAL YEAR 2002 SPECIAL FUND REVENUE

Agent / Broker Licensing Fees	5,425,301
Rate & Form Filing Fees	2,700,086
Insurance Company Examination Fees	2,794,466
Insurance Fraud Prevention Fee	1,716,650
Assessments	10,914,086
Company Licensing Fees	1,456,699
	25,007,288



MIA FISCAL YEAR 2002 EXPENDITURES

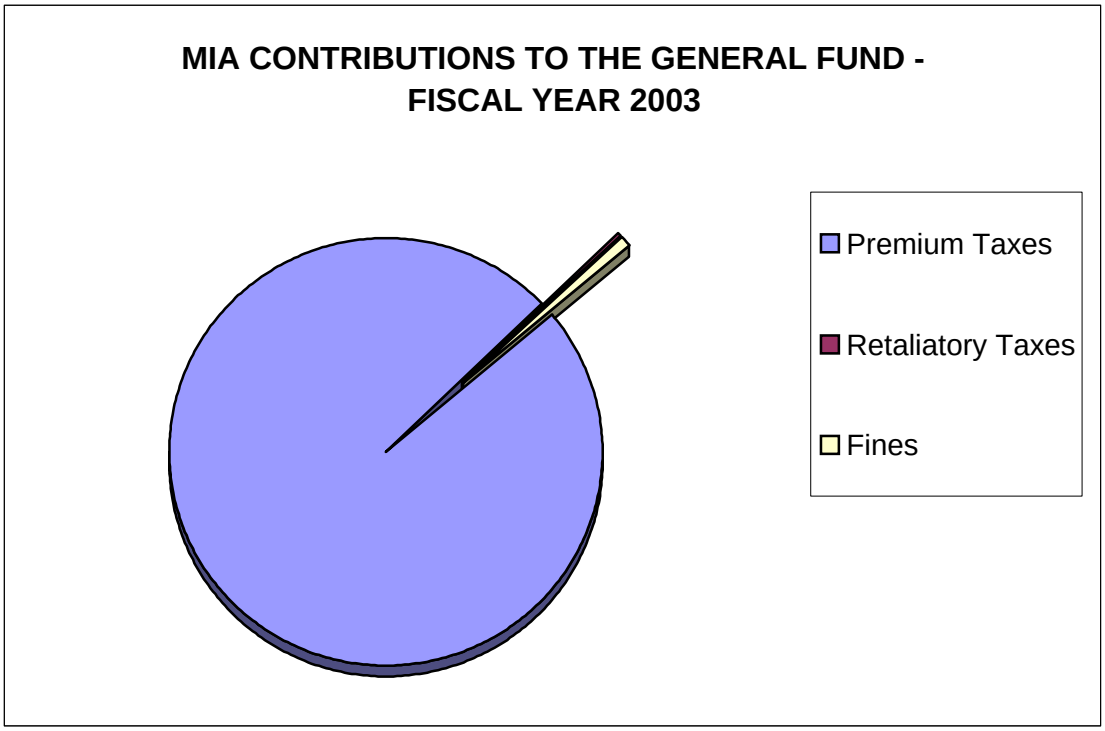
Salary and Wages	$ 15,237,665
Communications	299,730
Travel	470,431
Contractual Services	4,534,026
Supplies and Materials	176,249
Equipment	539,098
Office Rent & Utilities	880,474
	$ 22,137,673



Fiscal Information FY2003

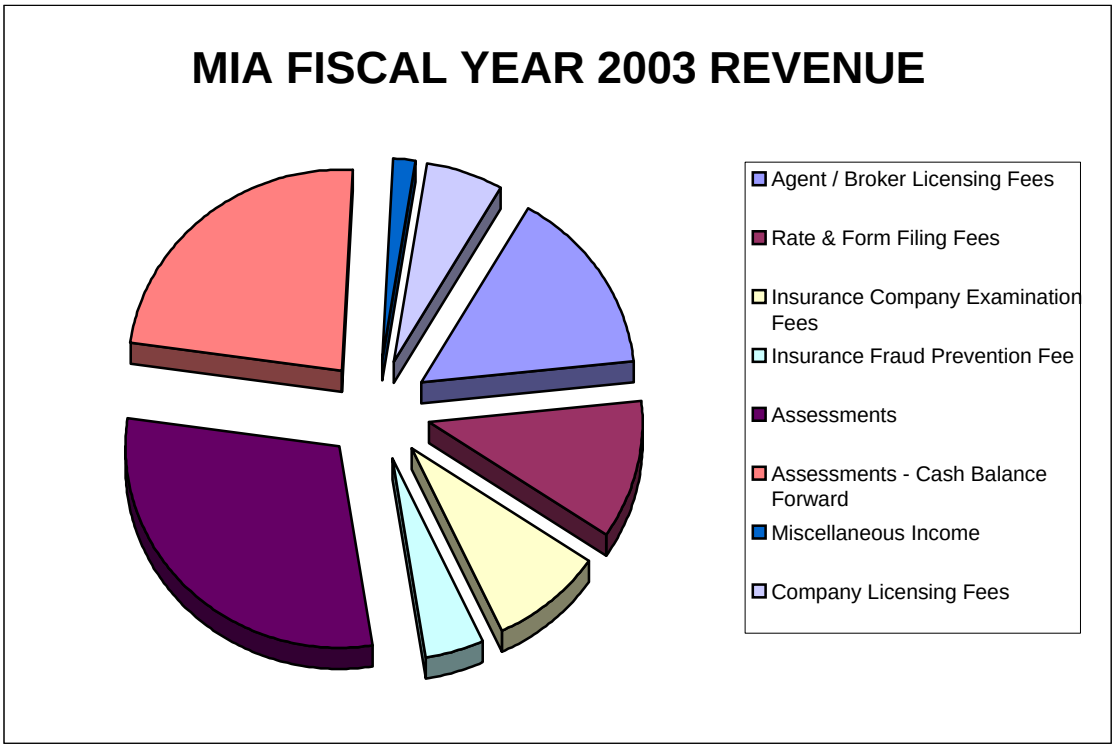
MIA CONTRIBUTIONS TO THE GENERAL FUND - FISCAL YEAR 2003

Premium Taxes	$ 227,826,846
Retaliatory Taxes	602,337
Fines	2,203,353
	230,632,536



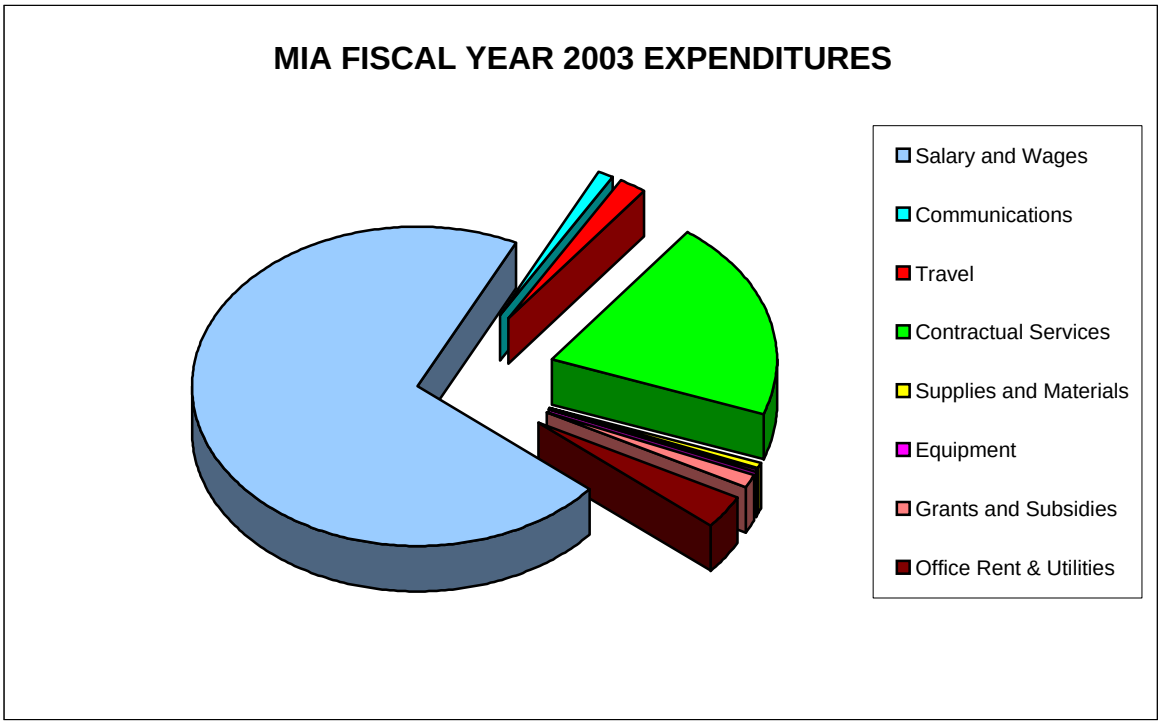
MIA FISCAL YEAR 2003 SPECIAL FUND REVENUE

Agent / Broker Licensing Fees	$	3,917,857
Rate & Form Filing Fees		2,872,459
Insurance Company Examination Fees		2,168,651
Insurance Fraud Prevention Fee		1,211,900
Assessments		7,666,126
Assessments - Cash Balance Forward		6,107,607
Miscellaneous Income		441,980
Company Licensing Fees		1,501,420
	$	25,888,000



MIA FISCAL YEAR 2003 EXPENDITURES

Salary and Wages	$ 15,912,920
Communications	270,794
Travel	425,119
Contractual Services	4,528,928
Supplies and Materials	142,954
Equipment	29,622
Grants and Subsidies	361,227
Office Rent & Utilities	726,162
	$ 22,397,726



Maryland Health Insurance Plan

The Maryland Health Insurance Plan (MHIP) is a State administered health insurance program for Marylander residents who do not have access to health insurance. The Maryland General Assembly established MHIP under the Health Insurance Safety Net Act of 2002. MHIP's eligibility criteria was expanded to include individuals who are eligible for the Federal Health Coverage Tax Credit, as required under HB 1100 which was signed by Governor Robert Ehrlich on April 8, 2003. An Executive Director was hired in late 2002 and operations began for members on July 1, 2003. MHIP operates as an independent unit within the Maryland Insurance Administration. The plan is governed by a Board of Directors consisting of the Insurance Commissioner, Secretary of the Department of Budget and Management, the Executive Director of the Maryland Health Care Commission, the Executive Director of the Health Services Cost Review Commission, and a consumer representative.

MHIP replaced the Substantial Available and Affordable Coverage (SAAC) program, known as the Open Enrollment product, operated by commercial insurance carriers in the State. In early 2003, Maryland Physicians Care was hired as Plan Administrator. Maryland Physicians Care is a managed care organization owned by Maryland General Health Systems, St. Agnes Healthcare, Washington County Health System, and Western Maryland Health System.

MHIP is financed through an assessment on hospital patient revenues and member premiums. MHIP has also received several grants from the Federal government.

Maryland residents are eligible for MHIP if:

- They are not eligible for group health coverage, COBRA, the Maryland Medical Assistance or Children's Health Programs, Medicare or any other government-sponsored health insurance program:
- They have exhausted all available group coverage or moved into Maryland from another state's high-risk pool;
- Have or have been offered health insurance that provides limited or restricted coverage or that excludes coverage for a specific medical condition or conditions;
- Are receiving a Federal Trade Readjustment Allowance or unemployment benefits under the Trade Adjustment Assistance program or are receiving pension payments from the Pension Benefit Guaranty Corporation; or
- Have been refused individual health insurance for medical reasons or have a specified medical condition.

More information on MHIP is available on their web site
***www.marylandhealthinsuranceplan.state.md.us*.**

2002 Insurance Legislation

Life & Health

HOUSE BILL 85 (Chapter 29) - Health Insurance - Small Group Market - Producer Commissions

Amends § 15-1206(f) of the Insurance Article to prohibit a carrier from implementing a producer commission schedule that varies the amount of a commission based on the size of a small employer group unless the variation:

(1) Is inversely related to the size of the small employer group;
(2) Applies to the cumulative premium paid over a specific period of time, is uniformly applied, and is inversely related to the cumulative premium paid during the period of time; or
(3) Is established by a contract between the carrier and each outside producer, and the carrier:
    (i) Specifies in the contract the group size to which the variation applies;
    (ii) Directs the outside producer to refer small employers of the specified size to an employee of the carrier who is a licensed producer or to a company affiliated with the carrier through common ownership within an insurance holding company; and
    (iii) Pays a commission to the employee producer described in item (ii) of this paragraph.

Effective date: June 1, 2002

HOUSE BILL 692 (Chapter 382) - Health Insurance - Habilitative Services - Modification and Clarification

Amends § 15-835 of the Insurance Article to:

- Clarify that a "congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect.

- Clarify that a "congenital or genetic birth defect" includes:
  (1) Autism or an autism spectrum disorder; and
  (2) Cerebral palsy.

- Clarify that "habilitative services" includes treatment for a child with a congenital or genetic birth defect.

Clarifies that a determination by a carrier denying a request for habilitative services or denying payment for habilitative services on the grounds that it is not a congenital or genetic birth defect is considered an adverse decision under § 15-10A-01 of the Insurance Article.

Effective date: October 1, 2002

HOUSE BILL 754 (Chapter 247) - <u>Health Insurance - Nonrenewal of Individual Health Benefit Plans - Requirements for Carriers with Affiliates</u>

Amends § 15-1308 of the Insurance Article to:

- Require a carrier that has an affiliate in the individual market to give notice to each affected individual, at least 180 days before the effective date of nonrenewal, of the individual's option to purchase all other individual health benefit plans currently offered by the affiliate of the carrier.

- Require a carrier that offers an individual health benefit plan to offer an individual health benefit plan to an individual who is nonrenewed by an affiliate of the carrier on a guarantee issue basis, if the individual applies for coverage no later than 63 days after the effective date of nonrenewal.

- Prohibit a carrier that issues coverage to an individual who is nonrenewed by an affiliate of the carrier from rating the coverage on a substandard basis unless the individual was rated on a substandard basis under the prior coverage.

- Require a carrier that issues coverage to an individual who is nonrenewed by an affiliate of the carrier to waive the waiting period for coverage of a preexisting condition to the extent that the individual has satisfied a waiting period under the individual's prior contract or policy.

- Permit a carrier that issues coverage to an individual who is nonrenewed by an affiliate of the carrier to require the individual to satisfy the remaining part of the waiting period if any part of the waiting period under the individual's prior contract or policy has not been satisfied, unless the coverage issued has a shorter waiting period.

Amends §27-603 of the Insurance Article to permit the Commissioner to 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 the Insurance Article.

Effective date: June 1, 2002

HOUSE BILL 805 (Chapter 250) - <u>Reimbursement of Health Care Providers</u>

Amends § 19-701.1(b)(1)(ii)(2) of the Health-General Article to:

- Reflect the name change of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services.

- Extend the sunset provision until June 30, 2005.

In addition, the bill:

- Requires the Maryland Health Care Commission and the Health Services Cost Review Commission to jointly study and make recommendations to the House Economic Matters and Senate Finance Committees regarding health care provider reimbursements by commercial insurers, including health maintenance organizations, and self-pay patients in the State.

- Requires the Commissions to make recommendations on certain issues listed in the bill.

- Requires the Board of Nursing, in consultation with representatives of health maintenance organizations, to report to the Senate Finance Committee and House Environmental Matters Committee on whether health maintenance organizations in this State should:
  (1) Individually credential nurse practitioners; and
  (2) Allow for the designation by a member or subscriber of a nurse practitioner as a primary care provider.

Effective date: June 1, 2002

HOUSE BILL 896 (Chapter 394) - <u>Health Insurance - Mental Illness - Coverage for Residential Crisis Services</u>

Amends § 15-840 of the Insurance Article to:

- Define "residential crisis services" in § 15-840 of the Insurance Article.

- Require certain carriers to provide coverage for medically necessary residential crisis services.

- Permit residential crisis services to be delivered under a managed care system.

Amends § 19-706 of the Health-General Article to apply the provisions of the bill to health maintenance organizations.

Effective date: October 1, 2002

HOUSE BILL 1158 (Chapter 409) - <u>Health Insurance - Continuation Coverage - Voluntary Termination of Employment</u>

- Amends the definition of "change in status" in § 15-409 of the Insurance Article to include:
  (1) Involuntary termination of the insured's employment other than for cause; and
  (2) Voluntary termination of the insured's employment by the insured employee.

- Requires the benefits under House Bill 1158 to be available to eligible individuals on and after the effective date of this Act, notwithstanding any policy or benefit statement to the contrary.

Effective date: October 1, 2002

HOUSE BILL 1192 (Chapter 411) - <u>Health Insurance - Coverage Under Medical Support Notices</u>

Among other things, alters the provisions of § 15-405 of the Insurance Article to:

- Prohibit an entity subject to the provisions of § 15-405 of the Insurance Article from denying enrollment of a child under the health insurance coverage of an insuring parent because the child is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

- Within 20 business days after receipt of a medical support notice from an employer, require a carrier:
  (1) To determine whether the medical support notice contains:
    (i) The employee's name and mailing address; and
    (ii) The child's name and the child's mailing address or the address of a substituted official;
  (2) If the medical support notice does not contain the information described in paragraph (1) above, to complete and forward the appropriate part of the medical support notice to the issuing child support enforcement agency advising that the medical support notice does not constitute a qualified medical child support order; and
  (3) If the medical support notice contains the information described in paragraph (1) above, to comply with the following requirements:
    (i) Determine the child's eligibility for enrollment;
    (ii) Complete and send the appropriate part of the medical support notice to the employer and the child support enforcement administration;
    (iii) Enroll the child if the child is eligible for enrollment, subject to § 15-405(G) of the Insurance Article;
    (iv) Send to the employee, child, and custodial parent of the child a written notice that explains that the coverage of the child is or will become available to the child; and
    (v) Send to the custodial parent of the child a written description of:
      1. The health insurance coverage;
      2. The effective date of coverage;

3. The employee's cost for the health insurance coverage; and
4. If not already provided:
   (a) A summary plan description;
   (b) Any forms, documents, or information necessary to effectuate coverage; and
   (c) Any information necessary to submit claims for benefits.

- Under § 15-405(G) of the Insurance Article, if the employee's eligibility for health insurance coverage is subject to a waiting period that has not been completed, require the carrier:
  (1) To complete and send the appropriate part of the medical support notice to the employer and the issuing child support agency within 20 business days after receipt of the medical support notice from the employer; and
  (2) On the employee's satisfaction of the waiting period, to complete enrollment of the child in accordance with the provisions of § 15-405(G)(1) of the Insurance Article and send the notice and information required under § 15-405(F)(3) of the Insurance Article.

- If the employee's health insurance plan requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, require the carrier to enroll both the employee and the child, without regard to enrollment period restrictions, within the time period specified in § 15-405(F) of the Insurance Article.

- If a child is eligible for enrollment, require the carrier to complete the enrollment without regard to enrollment period restrictions, within the time periods specified in § 15-405(F) and (G) of the Insurance Article.

- Permit the requirement for notification of the child under § 15-405(3)(v) of the Insurance Article to be satisfied by notifying the custodial parent if the child and the custodial parent live at the same address.

Effective date: July 1, 2002

HOUSE BILL 1228 (Chapter 153) - <u>Health Insurance Safety Net Act of 2002</u>

Amends § 19-219 of the Health-General Article to:

- Require the Health Services Cost Review Commission (HSCRC), among other things, to determine and collect funds necessary to operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

- Require each hospital to remit monthly one-twelfth of the amount determined under § 19-219(d)(4) of the Health-General Article to the Maryland Health Insurance Plan Fund.

Establishes Title 14, Subtitle 5 of the Insurance Article which:

- Establishes the Senior Prescription Drug Program.

- Establishes the Maryland Health Insurance Plan as an independent unit that operates in the Maryland Insurance Administration under Title 14, Subtitle 5 of the Insurance Article.
- Authorizes the Board to aggregate the purchasing of prescription drugs for enrollees in the Plan and enrollees in the Senior Prescription Drug Program established under Title 14, Subtitle 5, Part II of the Insurance Article.

- Establishes certain provisions under § 14-504 of the Insurance Article regarding the funding of the Fund and the collection and investment of the Fund.

Amends § 14-106 of the Insurance Article to require a nonprofit health service plan that is subject to § 14-106 of the Insurance Article and issues comprehensive health care benefits in Maryland to administer and subsidize the Senior Prescription Drug Program established under Title 14, Subtitle 5, Part II of the Insurance Article.

Amends § 15-1303 of the Insurance Article to:

- Require a carrier that offers individual health benefit plans in Maryland to submit to the Commissioner, no later than 30 days after the last day of the quarter, for each calendar quarter, a report that includes:
  (1) The number of applications submitted to the carrier for individual coverage; and
  (2) The number of declinations issued by the carrier for individual coverage.

- Require a carrier to file the above-mentioned report with the Commissioner no later than 30 days after the last day of the quarter for which the information is provided.

- Require a carrier that denies coverage to an individual under a medically underwritten health benefit plan to provide the individual with specific information regarding the availability of coverage under the Maryland Health Insurance Plan.

- Require a notice issued by a carrier under § 15-1303(c) of the Insurance Article to be in a manner and form approved by the Commissioner.

- Exempt the Maryland Health Insurance Plan from § 11-203 of the State Finance and Procurement Article.

In addition, the bill:

- Amends § 6-101(b) of the Insurance Article to exempt the Maryland Health Insurance Plan and the Senior Prescription Drug Program from the provisions of § 6-101(b) of the Insurance Article.

- Repeals a provision that prohibits the Health Services Cost Review Commission from eliminating or adjusting the differential in hospital rates provided to carriers that provide a substantial, available, and affordable product in the nongroup market.

- Alters the sunset date for Section 3 of Chapter 134 of the Acts of 2001.

- Alters the sunset date for Section 3 of Chapter 135 of the Acts of 2001.

- Terminates the SAAC program on July 1, 2003.

- Establishes July 1, 2003 as the renewal date for each SAAC policy in effect on or after March 31, 2003.

- As of July 1, 2003, requires each SAAC policy to be renewed as a policy under the Maryland Health Insurance Plan.

Effective date: July 1, 2002

HOUSE BILL 1254 (Chapter 154) - <u>Acquisition of a Nonprofit Health Entity - Determination by Regulating Entity</u>

Amends § 14-116 of the Insurance Article to:

- Prohibit a nonprofit health service plan that is formed or organized under Maryland law to:
  (1) Form or organize under the law of another jurisdiction unless the Commissioner determines that it is in the public interest; or
  (2) Alter its structure, operations, or affiliations, if such alteration results in the for-profit activities of the plan becoming so substantial that the Commissioner determines that the purpose of the nonprofit health service plan may no longer be characterized as operating a nonprofit health service plan.

- Authorize the Commissioner to revoke a certificate of authority issued to a foreign corporation subject to this subtitle if:
  (1) The foreign corporation operates a nonprofit health service plan that is affiliated with a nonprofit health service plan formed or organized under the laws of Maryland; and
  (2) The affiliation between the foreign nonprofit health service plan and the nonprofit health service plan formed under the laws of Maryland is terminated.

Amends § 14-139 of the Insurance Article to prohibit an officer, director, or trustee of a corporation operating under this subtitle from receiving any immediate or future remuneration as the result of an acquisition or proposed acquisition, as defined under § 6.5-101 of the State Government Article, except in the form of compensation paid for continued employment with the company or acquiring entity.

Amends § 6.5 -203 of the State Government Article to prohibit a determination made by the Commissioner under § 6.5-203(f) from taking effect until 90 calendar days after the date the determination is made.

Amends § 6.5-301 of the State Government Article in the following manner:

- An acquisition is not in the public interest unless appropriate steps have been taken to ensure that no officer, director, or trustee of the nonprofit health entity receives any immediate or future remuneration as the result of an acquisition or proposed acquisition except in the form of compensation paid for continued employment with the acquiring entity.

- Requires that the public or charitable assets distributed to a public or nonprofit charitable entity or trust in accordance with § 6.5-301(b)(2) of the State Government Article shall be in the form of cash.

- Requires the Commissioner to determine whether a payment by a nonprofit health entity, required under an agreement or contract for the acquisition of a nonprofit health entity if the agreement or contract is broken by the nonprofit health entity, is in the public interest.

Effective date: June 1, 2002

HOUSE BILL 1427 (Chapter 284) - <u>Health Insurance - Small Group - Open Enrollment Period</u>

Amends § 15-1210 of the Insurance Article to require a carrier that offers coverage to a small employer to establish an annual open enrollment period for self-employed individuals for at least 30 days in each 12-month period.

Effective date: October 1, 2002

SENATE BILL 90 (Chapter 117) - <u>Health Insurance - Health Maintenance Organizations and Managed Care Organizations - Application of Acquisitions Disclosure and Control Act</u>

Amends §§ 15-102.6 and 19-711 of the Health-General Article to:

- Apply the provisions of Title 7 of the Insurance Article to health maintenance organizations and managed care organizations.

- Require the Commissioner to adopt regulations that establish a materiality threshold for managed care organizations for reporting certain information to the Commissioner.

- Establish that a managed care organization is not subject to the provisions of § 15-102.6 of the Health-General Article until the effective date of the regulations that the Commissioner is required to adopt as described in the previous paragraph.

Repeals §§ 19-711(b) and 19-711.2 of the Health-General Article.

Effective date: October 1, 2002

SENATE BILL 388 (Chapter 23) - Maryland Group Health Insurance Plan - Repeal

Repeals the Maryland Group Health Insurance Plan provided for in Title 14, Subtitle 3, of the Insurance Article.

Effective date: June 1, 2002

SENATE BILL 487 (Chapter 155) - Acquisition of Nonprofit Health Entity - Conditions for Approval

- Amends § 6.5-203 of the State Government Article to repeal from existing law a provision that deems an application for conversion to a for-profit entity approved if the application is not approved or disapproved within 60 days after the record is closed.

- Amends § 6.5-301 of the State Government Article to prohibit the Commissioner from approving an acquisition unless the Commissioner finds that the acquisition is in the public interest.

Effective date: April 25, 2002

SENATE BILL 819 (Chapter 189) - Hospitals - Uniform Standard Credentialing Form

Among other things, authorizes the Commissioner to permit a carrier to use a health care facility's credentialing form to credential providers at that facility instead of the uniform credentialing form, if the carrier has designated the health care facility as the credentialing intermediary for the health care facility's physicians.

Effective date: July 1, 2002

Property & Casualty

HOUSE BILL 229 (Chapter 356) - Premium Finance Agreements - Delinquency and Collection Charge - Cancellation Charge

- Increases the maximum allowed delinquency and collection charge under § 23-306(b)(1) of the Insurance Article to $8.

- Increases the cancellation charge provided for under § 23-307(b)(1) of the Insurance Article to $15.

Effective date: October 1, 2002

HOUSE BILL 441 (Chapter 369) - <u>Title Insurance Producers and Agencies - Statements of Financial Condition - Repeal of Filing Requirement</u>

- Repeals § 10-121(j)(1) of the Insurance Article which requires a title insurer to have on file by December 31 of each year a statement of financial condition of each title insurance producer and agency with an appointment with the title insurer.

- Repeals § 10-125 (d)(4) of the Insurance Article which provides for an exemption to § 10-121(j) of the Insurance Article.

Effective date: October 1, 2002

HOUSE BILL 521 (Chapter 580) - <u>Property and Casualty Insurance - Use of Credit History</u>

Among other things, House Bill 521 amends § 27-501 of the Insurance Article in the following manner:

- With respect to homeowner's insurance, prohibits an insurer from:
  (1) Refusing to underwrite, cancel, or refuse to renew a risk based, in whole or in part, on the credit history of an applicant or insured;
  (2) Rating a risk based, in whole or in part, on the credit history of an applicant or insured in any manner; or
  (3) Requiring a particular payment plan based, in whole or in part, on the credit history of the insured or applicant.

- With respect to private passenger motor vehicle insurance, prohibits an insurer from:
  (1) Refusing to underwrite, cancel, refuse to renew or increase the renewal premium based, in whole or in part, on the credit history of the insured or applicant; or
  (2) Requiring a particular payment plan based, in whole or in part, on the credit history of the insured or applicant.

- Permits an insurer to use the credit history of an applicant to rate a new policy of private passenger motor vehicle insurance subject to certain provisions in § 27-501(E-I)(3)(II)(4) and (5).

In addition, the bill:

- Requires the Commissioner, in consultation with representatives of the property and casualty insurance industry, insurance producer organizations, and anyone else the Commissioner considers necessary, to conduct a study on whether the use of credit scoring in Maryland has an adverse impact on any demographic group defined by race or socio-economic status.

- Requires the Commissioner to study the impact of premium rates on policies issued by the Maryland Automobile Insurance Fund on the insurance market.

Effective date: October 1, 2002

HOUSE BILL 726 (Chapter 80) - <u>Insurance - Surplus Lines Brokers - Disclosure and Notification Requirements</u>

Amends § 27-216(d) of the Insurance Article to:

- Require a surplus lines broker to make a clear and conspicuous written disclosure of any financial interest in the person performing the inspection; and whether the surplus lines broker will receive compensation from the person that performs the inspection.

- Require a surplus lines broker to notify the prospective insured of the option to obtain the inspection from another person who meets the requirements of or is approved by the surplus lines insurer.

Effective date: October 1, 2002

HOUSE BILL 1002 (Chapter 553) - <u>Motor Vehicle Liability Insurance - Premium Increases - Consumer Information</u>

Defines certain terms.

Amends § 11-317 of the Insurance Article to require each insurer that provides a private passenger automobile insurance policy to provide a statement to the policyholder at the time of issuance or renewal of the policy that includes a general description of the factors that may cause or contribute to an increase in a policy premium and to make that statement available to its producers.

Amends § 27-501 of the Insurance Article to prohibit an insurer from requiring a particular payment plan for an insured for coverage under a private passenger or homeowner's insurance policy based on the credit history of the insured.

Amends § 27-605 of the Insurance Article in the following manner:

- Clarifies § 27-605(B) of the Insurance Article to prohibit an insurer, under certain circumstances, from increasing a premium for any coverage on a policy of motor vehicle liability insurance.

- Amends § 27-605(C)(3) of the Insurance Article to require an insurer to:

  State in the notice required under § 27-605(C) of the Insurance Article the amount of the increase and the type of coverage to which it is applicable.

  State in the notice required under § 27-605(C) of the Insurance Article the right of the insured to protest the proposed action of the insurer and, except in the case of a premium increase of 15 percent or less for the entire policy, request a hearing before the Commissioner on the proposed action by signing two copies of the notice and sending them to the Commissioner within 30 days after the mailing.

  Maintain an insured's current insurance in effect until a final determination is made by the Commissioner except for a premium increase of 15 percent or less for the entire policy.

- Prohibits the Commissioner from disallowing a proposed action of an insurer because the statement of actual reason contains:
  (1) Grammatical errors, typographical errors, or other errors provided that the errors are nonmaterial and not misleading; or
  (2) Surplus information, provided that the surplus information is nonmaterial and not misleading.

- Amends § 27-605(F)(5)(ii) of the Insurance Article to establish that in the case of a premium increase, a dismissal of the protest or disallowance of the premium increase is deemed to be a final determination of the Commissioner 20 days after the mailing date of the Commissioner's notice of action.

- Amends § 27-605(G)(4) of the Insurance Article to apply in the case of a premium increase of greater than 15 percent for the entire policy.

- If the Commissioner disallows a premium increase of 15 percent or less for the entire policy, requires the insurer, within 30 days after the disallowance, to:
  (1) Return to the insured all disallowed premium received from the insured; and
  (2) Pay to the insured interest on the disallowed premium received from the insured calculated at 10 percent per annum from the date the disallowed premium was received to the date the disallowed premium was returned.

- Establishes that if an insurer fails to return any disallowed premium or fails to pay interest to an insured, in violation of § 27-605(J) of the Insurance Article, the insurer is in violation of the Insurance Article and subject to the penalties under § 4-113(D) of this article.

In addition, the bill:

- Permits the Commissioner to adopt regulations that exclude from the requirements of § 27-605 of the Insurance Article certain types of premium increases except for premium increases due to:
  (1) An accident;
  (2) A violation of the Maryland vehicle law or the vehicle law of another state;
  (3) The claims history of the insured;
  (4) The credit history or the credit score of the insured;
  (5) A retiering of the insured; or
  (6) A surcharge.

- Requires the Commissioner, in consultation with private passenger automobile insurers, to conduct a study regarding the feasibility of establishing an internal grievance process for the resolution of complaints regarding proposed adverse action by insurers with respect to private passenger automobile insurance premium increase. The Commissioner shall make recommendations regarding the feasibility of establishing an internal grievance procedure to the House Economic Matters and Senate Finance Committees.

Effective date: October 1, 2002

Miscellaneous

HOUSE BILL 812 (Chapter 88) - <u>Motor Clubs - Required Security -Letters of Credit</u>

Amends § 26-204 of the Insurance Article to permit an applicant for a license to provide motor club services to submit a letter of credit in the form that the Commissioner requires and in an amount not less than $100,000 or, at the Commissioner's discretion, an amount not less than $15,000.

Effective date: October 1, 2002

HOUSE BILL 1456 (Chapter 286) - <u>Insurance - Certificate of Authority - Penalties</u>

For the purpose of determining the amount of any financial penalty or forfeiture to be imposed under § 4-112 of the Insurance Article, the Commissioner:
(1) Is required to consider the following factors:
  (i) The seriousness of the violation;
  (ii) The good faith of the violator;
  (iii) The violator's history of previous violations;

(iv) The deleterious effect of the violation on the public and the insurance industry; and
(v) The assets of the violator; and

(2) May determine the appropriate amount of the penalty or forfeiture.

Effective date: April 25, 2002

SENATE BILL 158 (Chapter 452) - <u>Maryland Insurance Administration - Subpoenas – Issuance</u>

Permits a subpoena issued under § 2-203 of the Insurance Article to be served in the same manner as a service of process in a civil action in a circuit court may be served.

Effective date: October 1, 2002

SENATE BILL 371 (Chapter 22) - <u>Injured Workers' Insurance Fund - Phase-In of Regulatory Requirements</u>

Amends § 10-125 of the Labor and Employment Article to:

- Clarify that the Fund is subject to certain provisions of the Insurance Article.
- Establish a phase-in schedule for the Fund to comply with the risk-based capital standards in the Insurance Article.
- Allow the Fund to exclude premium growth associated with the residual market business in any risk-based capital calculation if the Commissioner approves the definition of residual business used by the Fund.

Effective date: June 1, 2002

SENATE BILL 472 (Chapter 317) - <u>Maryland Insurance Administration - Program Evaluation</u>

Amends § 2-110(a) of the Insurance Article to:

- Require the Commissioner to prepare an annual report no later than December 31 of each year.
- Require the Commissioner to include additional information in the annual report.

Repeals §§ 2-105(e) and 2-406 of the Insurance Article.

Clarifies that the provisions of Title 27, Subtitle 4 of the Insurance Article (submission of an Antifraud plan to the MIA) apply to health maintenance organizations.

Repeals fees for appointments under § 2-112(a)(5).

Amends § 2-501 of the Insurance Article so that:

- The definition of "assessment" means an assessment that, subject to § 2-505(c)(3) of the Insurance Article, equals 60 percent of the Administration's approved annual budget appropriation.

- The definition of "health insurer assessment portion" means 40 percent of the assessment.

- The definition of "life insurer assessment portion" means 26 percent of the assessment.

- The definition of "property and casualty insurer assessment portion" means 34 percent of the assessment.

Amends § 2-503 of the Insurance Article to allow the Commissioner to determine the date on which the assessment is due to the Commissioner.

Amends § 2-505 to:

- Provide for, if in any given fiscal year the amount of revenue collected by the Commissioner and deposited into the Insurance Regulation Fund exceeds 105 percent of the actual appropriations for the Administration, the excess amount to be carried forward within the Insurance Regulation Fund.

- Require the assessment fee to be adjusted to maintain the fund at a level that does not exceed 105 percent of the Administration's approved annual budget.

Amends § 6-107(d) of the Insurance Article to require the Administration to distribute each quarter the amount necessary to administer the insurance premium tax laws in the previous quarter to an administrative account.

Requires the Maryland Insurance Administration to report to the Senate Finance Committee and the House Economic Matters Committee on or before October 1, 2002 on the implementation of the recommendations of the Department of Legislative Services contained in the sunset evaluation report dated October 2001. The report shall include:

(1) A summary of efforts by the Administration to enhance communication with licensees, to address staff vacancies in the Insurance Fraud Division, to attract and retain skilled staff, and to address issues related to its physical plant;
(2) Recommendations for consolidating statutorily required reports into the annual report; and
(3) Identification of statutory reporting requirements that are outdated or unnecessary.

Effective date: July 1, 2002

2003 Insurance Legislation

Life& Health

HOUSE BILL 17 (Chapter 270) - Maryland Pharmacy Assistance Program - Eligibility

Requires the Secretary of the Department of Health and Mental Hygiene to develop a program that will provide information to ineligible Maryland Pharmacy Assistance Program applicants regarding the programs they may be eligible for, including the Senior Prescription Drug Program established under Title 14, Subtitle 5 of the Insurance Article.

Effective date: July 1, 2003

HOUSE BILL 211 (Chapter 4) / SENATE BILL 450 (Chapter 3) - Short-Term Prescription Drug Subsidy Plan - Enrollment

- Establishes that the Short-Term Prescription Drug Subsidy Plan shall provide benefits to the maximum number of individuals eligible for enrollment in the program.

- Eliminates the cap that limits the program to 30,000 enrollees.

Effective date: April 8, 2003

HOUSE BILL 335 (Chapter 289) - Community Access Program Grants - Coordination of Health Care Provider Reimbursements - Pilot Programs

- Establishes § 15-1601 of the Insurance Article for the purpose of allowing recipients of a Community Access Program grant from the United States Department of Health and Human Services to establish a pilot program to coordinate health care provider reimbursements in order to test innovations in payment for health care services to be permanently implemented if successful.

- Establishes certain requirements for the pilot program.

- Establishes that a pilot program created under § 15-1601:

  (1) Is not providing insurance as defined in § 1-101 of the Insurance Article;
  (2) Is not subject to regulation by the Maryland Insurance Commissioner; and
  (3) Shall not be considered an unauthorized insurer as defined in § 1-101 of the Insurance Article.

A pilot program created under § 15-1601 of the Insurance Article shall report to the Senate Finance Committee and House Health and Government Operations Committee on or before June of each year.

Effective date: July 1, 2003 for a period of two years

HOUSE BILL 410 (Chapter 295) - Health Insurance - Private Review Agents - Examination of Pharmacy Benefit Managers

- Requires the Insurance Commissioner to conduct an examination, at least once every three years, of any pharmacy benefit manager registered as a private review agent to determine whether the pharmacy benefit manager is acting in compliance with § 15-10B of the Insurance Article.

- Requires the Insurance Commissioner to make a complete report of each examination of a pharmacy benefit manager conducted under § 15-10B-20 of the Insurance Article.

- Requires a pharmacy benefit manager subject to an examination under § 15-10B-20 of the Insurance Article to pay the expenses of the examination as required under § 2-208 of the Insurance Article.

- Establishes that a final report of an examination of a pharmacy benefit manager will be issued in accordance with § 2-209 of the Insurance Article.

Effective date: October 1, 2003

HOUSE BILL 498 (Chapter 41) - Health Insurance - Medicare Supplement Contracts - Availability

Requires a carrier that offers a Medicare supplement policy C or a Medicare supplement policy I to make those policies available to an individual who is under the age of 65 years but is eligible for Medicare due to a disability during the 6-month period following the applicant's enrollment in Part B of Medicare.

Effective date: July 1, 2003

HOUSE BILL 499 (Chapter 305) - Maryland Insurance Administration - Disability Benefits - Adoption of Regulations

- Defines "Disability Benefit" to mean a benefit that is payable based on the disability of a covered individual.

- Disability benefit does not include:

(1) Long-term care insurance;
(2) A benefit that is payable based solely on a dismemberment of a covered individual;
(3) Benefits in a life insurance policy that operate to safeguard the contract from lapse or to provide a special surrender value, special benefit, or annuity in the event of total and permanent disability; or
(4) Benefits in a health insurance policy that operate to safeguard the contract from lapse due to disability.

- Defines "adverse benefit determination" to mean:
(1) A denial, reduction, or termination of a disability benefit;
(2) A failure to provide or make payment, in whole or in part, for a disability benefit; or
(3) Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for coverage of a disability benefit.

- Requires the Insurance Commissioner to adopt regulations that establish standards governing the processing of claims by an insurer that issues or delivers:
(1) Individual policies in the State that include a disability benefit, or
(2) Group policies in the State that include a disability benefit.

- The regulations adopted under this law shall establish and maintain reasonable claims procedures governing the filing of disability benefit claims.

- Requires the claims procedures established under this law for individual policies and group policies to be consistent with the provisions of the Department of Labor's regulations entitled "Employee Retirement Income Security Act of l974, Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule" (29 CFR 2560).

- Establishes that the regulations adopted under § 15-1010(b)(1)(i) of the Insurance Article governing individual disability benefit policies may not take effect until July 1, 2004.

Effective date: October 1, 2003

HOUSE BILL 605 (Chapter 437) - <u>Maryland Health Care Commission - Evaluation of Mandated Health Insurance Services</u>

- Amends § 15-1502 of the Insurance Article to require the Maryland Health Care Commission to conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision-making criteria for reducing the number of mandates or the extent of coverage.

- Requires the Maryland Health Care Commission to consider certain factors when evaluating existing mandated health insurance services.

- Requires the Maryland Health Care Commission, beginning on January 1, 2004, and every four years after, to submit a report of its findings to the General Assembly.

Effective date: July 1, 2003

HOUSE BILL 656 (Chapter 440) - <u>Health Maintenance Organizations - Definition of Covered Service</u>

- Alters the definition of "covered service" to mean a health care service included in the benefit package of the health maintenance organization and rendered to a member or subscriber of the health maintenance organization by:
  - A provider under contract with the health maintenance organization, when the service is obtained in accordance with the terms of the benefit contract of the member or subscriber; or
  - A noncontracting provider under § 19-710.1 of the Insurance Article when the service is:
    (1) Obtained in accordance with the terms of the benefit contract of the member or subscriber;
    (2) Obtained pursuant to a verbal or written referral by:
    The health maintenance organization of the member or subscriber; or
    A provider under written contract with the health maintenance organization of the member or subscriber; or
    Preauthorized or otherwise approved either verbally or in writing by:
    The health maintenance organization of the member or subscriber; or a provider under written contract with the health maintenance organization of the member or subscriber.

Under § 19-710(p)(3)(ii) of the Insurance Article, clarifies that a health care provider or a representative of a health care provider may collect or attempt to collect from a subscriber or enrollee "any payment or charges for services that are not covered services."

Effective date: October 1, 2003

HOUSE BILL 700 (Chapter 321) - <u>Health Insurance - Private Review Agents - Certification</u>

- Allows the Insurance Commissioner to consider an applicant for certification as a private review agent to have met certain certification requirements under § 15-10B of the Insurance Article if:

(1) The applicant has obtained utilization management accreditation from an approved accrediting organization as determined by the Insurance Commissioner;

(2) The approved accrediting organization has requirements that meet or exceed the particular requirement in § 15-10B of the Insurance Article; and

(3) The applicant demonstrates that the applicant meets or exceeds the particular requirement under § 15-10B of the Insurance Article.

- Prohibits the Insurance Commissioner from issuing a certificate to an applicant with utilization management accreditation by an approved accrediting organization unless the applicant meets all the requirements of § 15-10B of the Insurance Article and all applicable regulations of the Insurance Commissioner.

- Establishes that a report of an approved accrediting organization used by the Insurance Commissioner as evidence that the applicant has met a particular requirement for a private review agent certificate shall be made available by the Insurance Commissioner to the public on request.

Effective date: October 1, 2003

HOUSE BILL 729 (Chapter 323) - <u>Health Insurance - Managed Behavioral Health Care Services - Reports</u>

- Among other things, requires the Insurance Commissioner to develop a form to implement the requirements of § 15-127(D) of the Insurance Article.

- Amends § 15-127 of the Insurance Article to define certain terms.

- Establishes that the provisions of § 15-127 of the Insurance Article do not apply to a person that, for an administrative fee only, solely arranges a provider panel for a carrier for the provision of behavioral health care services on a discounted fee-for-service basis.

- Requires a carrier that owns or contracts with a managed behavioral health care organization to:
  (1) Include information on behavioral health care providers in the list of providers on the carrier's provider panel required under § 15-112(j) of the Insurance Article.
  (2) Provide the same information on behavioral health care providers that is required for other providers under § 15-112(j) of the Insurance Article.

- Amends § 15-127(c) to require a carrier that contracts with a managed behavioral health care organization to require the managed behavioral health care organization to provide to the carrier on an annual basis a report on the direct behavioral health care expenses of the managed behavioral health care organization.

- The report required to be provided under § 15-127(c)(4) of the Insurance Article shall be made publicly available by the carrier.

- Under § 15-127(e)(2) of the Insurance Article, a carrier required to make a form publicly available under § 15-127(c)(4) of the Insurance Article may charge a fee.

Effective date: October 1, 2003

HOUSE BILL 803 (Chapter 1) - <u>Maryland Health Insurance Plan and Senior Prescription Drug Program - Modifications and Clarifications</u>

- Among other things, amends § 14-504 of the Insurance Article to require the Plan administrator to deposit all premiums for plan enrollees in a separate account, titled in the name of the State of Maryland, for the Maryland Health Insurance Plan.

- Establishes that the Plan administrator may use the money in the account only to pay claims for plan enrollees.

- Requires the Plan administrator to keep complete and accurate records of all transactions for the separate account.

- Allows the Maryland Health Insurance Plan Board to adjust the premium rate based on member age under certain circumstances.

- Amends § 14-513 of the Insurance Article to allow the Board to determine whether premiums collected for the Program shall be deposited:
  (1) To a segregated account in the Fund established under § 14-504 of the Insurance Article; or
  (2) To a separate account for the Program established by the carrier that administers the Program.

- For the final quarter of fiscal year 2003, establishes that the Health Services Cost Review Commission shall determine the amount equal to the value of the SAAC purchaser differential for each hospital for which rates have been approved by the Commission.

Effective date: April 8, 2003

HOUSE BILL 894 (Chapter 338) - <u>Health Insurance - Reimbursement for Provider Services - Professional Counselors and Therapists</u>

- Applies to each individual, group, or blanket health insurance policy, contract, or certificate of an insurer or nonprofit health service plan that :

  (1) Is delivered or issued for delivery in the State;
  (2) Is issued to a group that is incorporated or has a main office in the State; or
  (3) Covers individuals who reside or work in the State; and

(4) Is issued, renewed, amended, or reissued on or after October 1, 2003.

- Establishes that if a policy, contract, or certificate subject to this law provides for reimbursement for a service that is within the lawful scope of practice of a licensed clinical professional counselor, a licensed clinical marriage and family therapist, or a licensed clinical alcohol and drug counselor, the insured or any other person covered by the policy or certificate is entitled to reimbursement for the service.

Effective date: October 1, 2003

HOUSE BILL 974 (Chapter 461) / SENATE BILL 687 (Chapter 261) - Health Maintenance Organizations - Patient Access to Choice of Provider

- Amends § 19-705.1(b) of the Health-General Article to require the Secretary of the Department of Health and Mental Hygiene to include in the standards of quality of care a requirement that each member of a health maintenance organization shall have an opportunity to select a primary physician or a certified nurse practitioner from among those available to the health maintenance organization.

- Under § 19-705.1(c), provides that a member of a health maintenance organization may select a certified nurse practitioner as the member's primary care provider if:

(1) The certified nurse practitioner provides services at the same location as the certified nurse practitioner's collaborating physician; and
(2) The collaborating physician provides the continuing medical management required under § 19-705.1(b)(5) of the Health-General Article.

- Under § 19-705.1(c) of the Health-General Article, a member who selects a certified nurse practitioner as a primary care provider must be provided the name and contact information of the certified nurse practitioner's collaborating physician.

- In accordance with § 19-705.1(c)(3) of the Health-General Article, a health maintenance organization is not required to include certified nurse practitioners on the health maintenance organization's provider panel as primary care providers.

Effective date: October 1, 2003

HOUSE BILL 1100 (Chapter 2) - Health Insurance Coverage Availability Act of 2003

- Amends § 14-501 of the Insurance Article by expanding the definition of ”medically uninsurable individual" to include individuals "eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code."

- Amends § 14-503 of the Insurance Article to add two members to the Maryland Health Insurance Plan Board of Directors, appointed by the Insurance Commissioner, of which one member shall be a representative of carriers operating in the State and one member shall be a representative of insurance producers selling insurance in the State.

- Under §14-503(L) of the Insurance Article, the bill requires that for members enrolled in the Plan based on eligibility for the federal tax credit for health insurance costs under § 35 of the Internal Revenue Code, the Board shall report to the Governor and General Assembly by December 1 of each year the number of members enrolled and the cost to the Plan associated with providing coverage to these members.

- The bill also requires that a carrier that issues Medigap shall issue any Medigap policy the carrier sells in the State to an individual eligible for Medicare if:

  (1) The individual is enrolled under an employee welfare benefit plan that provides health benefits;
  (2) The employee welfare benefit plan in which the individual is enrolled terminates;
  (3) Solely because of eligibility for Medicare, the individual is not eligible for credit for health insurance costs under § 35 of the Internal Revenue Code and enrollment in the Maryland Health Insurance Plan under § 14-501(f) of the Insurance Article, as enacted by Section 1 of this Act; and
  (4) The individual applies for the Medigap policy no later than 63 days after the employee welfare benefit plan terminates.

- Requires the Maryland Insurance Administration to issue notice of the requirements regarding Medigap to each affected carrier in the State.

- Requires the Maryland Insurance Administration, on or before October 1, 2003, to notify the Centers for Medicare and Medicaid Services that the State has established the Plan and requests that the Plan be approved as an acceptable "alternative mechanism" under the Federal Health Insurance Portability and Accountability Act - 45 CFR 148.128(e).

Effective date: April 8, 2003

HOUSE BILL 1179 (Chapter 357) / SENATE BILL 772 (Chapter 356) - <u>Health Insurance - Nonprofit Health Service Plans - Reform</u>

- Establishes that the purpose of § 14-102 of the Insurance Article is to:
  (1) Regulate the formation and operation of nonprofit health service plans in the State; and
  (2) To promote the formation and existence of nonprofit health service plans in the State that:
  Are committed to a nonprofit corporate structure;
  Seek to provide individuals, businesses, and other groups with

affordable and accessible health insurance; and
Recognize a responsibility to contribute to the improvement of the overall health status of Maryland residents.

- Establishes that a nonprofit health service plan that complies with the provisions of § 14-102 of the Insurance Article is declared to be a public benefit corporation that is exempt from taxation as provided by law.

- Under § 14-102(c) of the Insurance Article, establishes the mission of the nonprofit health service plan.

- Under § 14-102(d) of the Insurance Article, requires a nonprofit health service plan to:

  (1) Develop goals, objectives, and strategies for carrying out its statutory mission;
  (2) For a certain period of time, report quarterly, for the preceding quarter, to the Joint Nonprofit Health Service Plan Oversight Committee on the nonprofit health service plan's compliance with the provisions of Title 14 of the Insurance Article; and
  (3) Provide to the Joint Nonprofit Health Service Plan Oversight Committee any other information necessary for the Committee to meet the goals outlined under § 2-10A-08 of the State Government Article.

- Applies to:
  (1) A nonprofit health service plan that is issued a certificate of authority in the State, whether or not organized under the laws of the State; and
  (2) An insurer or health maintenance organization, whether or not organized as a nonprofit corporation, that is wholly owned or controlled by a nonprofit health service plan that is issued a certificate of authority in the State.

- Under § 14-102(h) of the Insurance Article, exempts certain nonprofit health service plans from the provisions of the law.

- Under § 14-106(c) of the Insurance Article, amends the manner in which a nonprofit health service plan may satisfy the public service requirement.

- Under § 14-106(d) of the Insurance Article, requires a nonprofit health service plan that is subject to this law and issues comprehensive health care benefits in the State to:

  (1) Offer health care products in the individual market;
  (2) Offer health care products in the small employer group market in accordance with Title 15, Subtitle 12 of the Insurance Article; and
  (3) Administer and subsidize the Senior Prescription Drug Program established under Title 14, Subtitle 5, Part II of the Insurance Article.

Effective date: May 22, 2003

SENATE BILL 39 (Chapter 59) - Health Insurance - Coverage for Home Visits After Mastectomy or Surgical Removal of a Testicle - Extension of Sunset

- Extends the sunset provision in § 15-832 of the Insurance Article.

- Provides for § 15-832 of the Insurance Article to sunset on September 30, 2006.

Effective date: October 1, 2003

SENATE BILL 148 (Chapter 15) - Health Insurance - Medical Clinical Trials - Reporting Requirements

- Repeals uncodified language from Chapter 119 of the Acts of 1998 that required each insurer, nonprofit health service plan, and health maintenance organization subject to the Act to submit to the Insurance Commissioner a report that describes the clinical trials covered during the previous year.

- Repeals uncodified language from Chapter 119 of the Acts of 1998 that required the Insurance Commissioner to compile an annual summary report based on certain information provided to the Insurance Commissioner on clinical trials.

Effective date: June 1, 2003

SENATE BILL 252 (Chapter 224) - Health Insurance - Task Force to Study Access to Mental Health Services

- Establishes a task force to study and make recommendations regarding:

(1) Whether any changes should be made to the mental health parity requirements under § 15-802 of the Insurance Article and § 19-703.1 of the Health-General Article;
(2) The systematic barriers experienced by commercially insured individuals when attempting to access community treatment;
(3) How to ensure that commercially-insured individuals have access to medically necessary mental health treatment;
(4) The difference in mental health services coverage provided by the public mental health system, commercial health insurers, and commercial health maintenance organizations;
(5) The structure and effectiveness of the public and private mental health care delivery systems in the State; and
(6) The impact on the cost of health care coverage in the State of any recommended changes to the coverage or delivery of mental health care services.

- Requires the Task Force to issue a preliminary report of its findings on or before December 31, 2003 and a final report of its findings on or before December 31, 2004.

- Requires the Maryland Insurance Administration and the Department of Health and Mental Hygiene to jointly staff the Task Force.

- Establishes the membership of the Task Force, including the Insurance Commissioner or his designee.

- Requires the Insurance Commissioner to appoint two members of the Task Force:
  (1) One representative of the commercial health insurance industry; and
  (2) One representative of a commercial health maintenance organization.

Effective date: July 1, 2003

SENATE BILL 333 (Chapter 82) - <u>Individual Deferred Annuities - Minimum Nonforfeiture Amount - Interest Rate on Accumulations</u>

Amends § 16-504 of the Insurance Article so that the minimum nonforfeiture amount, under certain circumstances, is at an interest rate of 1.5% per year.

Imposes a two-year sunset provision so that the law expires May 31, 2005.

Effective date: June 1, 2003

SENATE BILL 477 (Chapter 93) - <u>Small Business Health Insurance Affordability Act</u>

- Amends § 15-1204 of the Insurance Article to permit a carrier to offer benefits in addition to those in the Standard Plan if, among other things, the carrier:

  (1) Clearly distinguishes the Standard Plan from other offerings of the carrier;
  (2) Indicates the Standard Plan is the only plan required by State law; and
  (3) Specifies that all enhancements to the Standard Plan are not required by State law.

- Amends § 15-1207 of the Insurance Article to lower the rate cap for the Standard Plan from 12% to 10%.

- Requires the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration, to conduct an analysis of and make recommendations on the administrative cost of health plans in the small group market, including:

  (1) The total amount and distribution of administrative costs;
  (2) The strategies of lowering administrative costs; and

(3) The appropriateness of the medical loss ratios specified in § 15-605(c)(1) of the Insurance Article.

Effective date: July 1, 2003

SENATE BILL 658 (Chapter 400) - <u>Life Insurance - Prohibited Use of Terrorism Exclusions</u>

- Amends § 16-215 of the Insurance Article to clarify that a policy of individual life insurance may not be delivered or issued for delivery in the State if the policy excludes or restricts liability for death that is the result of an act of terrorism that the covered person did not commit and in which the covered person did not participate.

- Amends § 17-101 of the Insurance Article to prohibit the delivery or issuance for delivery in the State of a policy of group life insurance if the policy excludes or restricts liability for death that is the result of an act of terrorism that the covered person did not commit and in which the covered person did not participate.

Effective date: July 1, 2003

SENATE BILL 672 (Chapter 259) - <u>Health Insurance - Provider Panels - Lists of Providers</u>

- Amends § 15-112(j) of the Insurance Article to:

(1) Require a carrier to make available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form:
A list of providers on the carrier's provider panel; and
Information on providers that are no longer accepting new patients.
(2) Require a carrier to notify each enrollee at the time of initial enrollment and renewal how to obtain the following information on the Internet and in printed form:
A list of providers on the carrier's provider panel; and
Information on providers that are no longer accepting new patients.

Effective date: October 1, 2003

Property & Casualty

HOUSE BILL 641 (Chapter 439) - <u>Motor Vehicle Liability Insurance - Valuation of Motor Vehicles</u>

Under § 27-304.1 of the Insurance Article, requires the Insurance Commissioner to adopt regulations that establish standards and procedures for:

(1) The settlement of claims involving the total loss of a private passenger motor vehicle; and
(2) The determination of the private passenger motor vehicle's total loss value.

Effective date: October 1, 2003

HOUSE BILL 1125 (Chapter 472) - Private Passenger Motor Vehicle Insurance - Underwriting Standards - Statistical Validation

Amends § 27-501(I)(1)(vi) of the Insurance Article to clarify that a violation of § 21-902(a), (c), or (d) of the Transportation Article does not require statistical validation for an insurer to cancel or refuse to underwrite or renew an insurance risk pursuant to § 27-501 of the Insurance Article.

Effective date: June 1, 2003

HOUSE BILL 1153 (Chapter 355) - Insurance - Maryland Property Insurance Availability Act

- Amends § 25-405(f)(1) of the Insurance Article to increase the maximum limit of liability from $500,000 to $1,500,000 on real or personal property comprised of or contained in a single building.

- Repeals § 25-405(f)(1)(ii), which subjects contiguous parcels of land to the maximum limit of liability.

Effective date: October 1, 2003

SENATE BILL 167 (Chapter 69) - Insurance - Premium Finance - Agreements

- Under § 23-301.1 of the Insurance Article, authorizes a premium finance agreement to include any:

  (1) Premium receipts tax that a surplus lines broker is required to charge under § 3-324 of the Insurance Article and pay to the Insurance Commissioner under § 3-325 of the Insurance Article;
  (2) Policy fee that a surplus lines broker is allowed to charge under § 27-216 of the Insurance Article; and
  (3) Inspection fee that a surplus lines broker is allowed to charge under § 27-216 of the Insurance Article.

- Amends § 23-304 of the Insurance Article to require the finance charge to be computed on the amount of the entire premium loan advanced, including any taxes or fees that are financed under § 23-301.1 of the Insurance Article.

  Effective date: October 1, 2003

Miscelleanous

HOUSE BILL 114 (Chapter 119) - <u>Insurance - Reinsurance - Ceding Insurers</u>

- Establishes under § 5-904 of the Insurance Article that credit may not be allowed, as an asset or deduction from liability, to a ceding insurer for reinsurance, unless:

  (1) The reinsurer is authorized to transact insurance business in the State or is a solvent insurer approved or accepted by the Insurance Commissioner for the purpose of reinsurance; and
  (2) The reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer the reinsurance shall be payable under the terms of a contract reinsured by the reinsurer on the basis of reported claims allowed by the court in a liquidation proceeding, without diminution because of the insolvency of the ceding insurer.

- Section 5-904(a)(2) requires that payments made by a reinsurer in accordance with § 5-904(a)(1)(II) to be made directly to the ceding insurer or its domiciliary receiver unless:

  (1) The reinsurance contract or other written agreement specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer; or
  (2) Subject to any contractual or statutory requirement of consent by the policyholder, the reinsurer has assumed the policy obligations of the ceding insurer as direct obligations of the reinsurer to the payees under the policies and in substitution for the ceding insurer's obligations to the payees.

- Under § 5-904(a)(3), establishes the rights and obligations of a reinsurer in the event that a life and health guaranty association has elected to succeed the rights and obligations of an insolvent insurer.

- Under § 5-904(B) of the Insurance Article, provides a reinsurer with certain rights, including the right to investigate a claim and interpose, in the liquidation proceeding, any defense that it determines is available to the insolvent ceding insurer or its receiver.

Effective date: October 1, 2003

HOUSE BILL 200 (Chapter 35) - <u>Insurance - Regulation of Insurance Producers</u>

- Amends § 2-112 of the Insurance Article to repeal the current fee for approval by the Insurance Commissioner of continuing education courses.

- Amends § 10-110 of the Insurance Article to allow the Insurance Commissioner to appoint an advisory board for life and health insurance and an advisory board for property and casualty insurance.

- Amends § 10-116 of the Insurance Article to allow the Insurance Commissioner to review continuing education courses and approve or disapprove continuing education courses.

- Amends § 10-118 of the Insurance Article to require insurers to maintain a producer register in lieu of filing a notice of every producer appointment or termination with the Insurance Commissioner.

Effective date: July 1, 2003 **(The provisions in § 10-118 of the Insurance Article take effect on January 1, 2004.)**

HOUSE BILL 711 (Chapter 173) - <u>Insurance - Offers of Educational or Promotional Materials or Articles of Merchandise</u>

- Amends § 27-209(4) of the Insurance Article to prohibit a person from knowingly offering, promising or giving any valuable consideration not specified in the contract, except for educational materials, promotional materials, or articles of merchandise that cost less than $10, regardless of whether a policy is purchased.

- Amends § 27-212 of the Insurance Article to prohibit a person from knowingly offering, promising, or giving any valuable consideration not specified in the contract, except for educational materials, promotional materials, or articles of merchandise that cost less than $10, regardless of whether a policy is purchased.

Effective date: October 1, 2003

HOUSE BILL 1037 (Chapter 193) - <u>Life Insurers - Board of Directors - Investments Practices</u>

- Amends § 5-505 of the Insurance Article to require certain insurers and their boards to behave in a certain manner when making investments or loans.

- Amends § 5-511 of the Insurance Article to allow insurers to invest in certain classes of investments.

- Amends § 5-511 to define limits on an insurer's ability to invest in medium-grade and lower-grade securities.

Effective date: October 1, 2003

SENATE BILL 85 (Chapter 60) - Injured Workers' Insurance Fund - Risk Based Capital - Exemption from Excessive Premium Growth Charge

- Amends § 10-125(f) of the Labor and Employment Article so that the Fund is not subject to the excessive premium growth charge or any other penalty associated with premium growth in any risk based capital calculation.

- Section 10-125(f) of the Labor and Employment Article is effective until January 1, 2005.

Effective date: October 1, 2003

SENATE BILL 601 (Chapter 106) - Life Insurance - Separate Investment Accounts - Asset Holding Requirements

- Amends § 5-512(k)(2) of the Insurance Article so that if a separate investment account provides a fixed guaranteed return that is not subject to market value adjustment, a life insurer is required to hold assets that equal or exceed the reserve amount that would be required if the separate investment account was an obligation of the life insurer's general account.

- Requires an asset held under § 5-512(k)(2)((I) to be valued in accordance with §§ 5-401 and 5-402 of the Insurance Article.

Effective date: October 1, 2003

SENATE BILL 652 (Chapter 399) - Insurers - Assets and Investments - Location

- Exempts a domestic insurer from keeping certain assets in the State.

- Under § 4-115(c)(1)(ii)(4) of the Insurance Article, exempts securities held either by the insurer or in compliance with regulations adopted by the Insurance Commissioner.

- Under § 4-115(c)(1)(ii)(5) of the Insurance Article, exempts transactions or securities involved in transactions authorized by § 5-111(n) and (o) of the Insurance Article or any other transactions exempted by the Insurance Commissioner from this paragraph.

- Repeals § 4-115(d) of the Insurance Article, which prohibits a domestic insurer from keeping more than 15% of the domestic insurer's admitted assets outside of the State.

- Amends § 5-511(o)(2)(ii)(1.) of the Insurance Article to require the board of directors to approve a derivative use plan that, among other things:
  "Describes investment objectives and risk constraints, such as counterparty exposure amounts and collateral arrangements supporting derivative transactions".

  Effective date: October 1, 2003

Implementation of 2002 Legislation

Bill No. and Title	Regulations	Study/Report
HB 521 - Property and Casualty Insurance - Use of Credit History ***Effective date: October 1, 2002***		(1)Requires the Commissioner, in consultation with representatives of the property and casualty insurance industry, insurance producer organizations, and anyone else the Commissioner considers necessary, to conduct a study on whether the use of credit scoring in Maryland has an adverse impact on any demographic group defined by race or socio-economic group. (2) Requires the Commissioner to study the impact of premium rates on policies issued by the Maryland Automobile Insurance Fund on the insurance market. (3) The Commissioner shall report on the results of these studies to the Governor and Legislature on or before January 1, 2004.
HB 1002 - Motor Vehicle Liability Insurance - Premium Increases - Consumer Information ***Effective date: October 1, 2002***		Requires the Commissioner, in consultation with private passenger automobile (PPA) insurers, to conduct a study regarding the feasibility of establishing an internal grievance procedure for the resolution of complaints regarding proposed adverse action by insurers with respect to PPA premium increases. On or before December 15, 2002, the Commissioner shall make recommendations regarding the feasibility of establishing an internal grievance procedure to the House Economic Matters and the Senate Finance Committees.

HB 1228 - Health Insurance Safety Net Act of 2002 ***Effective date: July 1, 2002***	Establish the Maryland Health Insurance Plan as an independent unit of the MIA.	
SB 90 - Health Insurance - Health Maintenance Organizations and Managed Care Organizations - Application of Acquisitions Disclosure and Control Act ***Effective date: October 1, 2002***	Requires the Commissioner to adopt regulations that establish a materiality threshold for reporting certain information to the Commissioner.	
SB 472 - Maryland Insurance Administration - Program Evaluation ***Effective date: July 1, 2002***		(1) Requires the Commissioner to prepare an Annual Report no later than December 31 of each year and requires that certain information be included in the Annual Report. (2) Requires the MIA to report to the Senate Finance Committee and the House Economic Matters Committee on or before October 1, 2002 on the implementation of the recommendations of the Department of Legislative Services contained in the sunset evaluation report dated October 2001. The report shall include: (1) A summary of efforts by the Administration to enhance communication with licensees, to address staff vacancies in the Insurance Fraud Division, to attract and retain skilled staff, and to address issues related to its physical plant; (2) Recommendations for consolidating statutorily required reports into the annual report; and (3) Identification of statutory reporting requirements that are outdated or unnecessary.

Implementation of 2003 Legislation

Bill No. and Title	Regulations	Reports	Task Force
HB 200 - Insurance - Regulation of Insurance Producers *Effective date: July 1, 2003* *The provisions in § 10-118 of the Insurance Article take effect on January 1, 2004.*	Adopt regulations to implement the provisions of § 10-118 of the Insurance Article.		
HB 641 - Motor Vehicle Liability Insurance - Valuation of Motor Vehicles *Effective date: October 1, 2003*	Adopt regulations that establish standards and procedures for: (1) the settlement of claims involving the total loss of a private passenger motor vehicle; and (2) the determination of the private passenger motor vehicle's total loss value.		
HB 700 - Health Insurance - Private Review Agents - Certification *Effective date: October 1, 2003*	Adopt regulations to implement the provisions of § 15-10B-03 of the Insurance Article to allow the Insurance Commissioner to consider an applicant for PRA certification to have met a particular certification requirement under certain circumstances.		
HB 729 - Health Insurance – Managed Behavioral Care	Requires the Insurance Commissioner to develop the form		

Bill No. and Title	Regulations	Reports	Task Force
Services - Reports *Effective date: October 1, 2003*	to be used by health carriers to report on the direct behavioral health care expenses of the managed behavioral health care organization that the carrier contracts with to provide services on its behalf.		
HB 1100 - Health Insurance Coverage Availability Act of 2003 *Effective date: April 8, 2003*	Requires a bulletin to be sent to all Medigap carriers.	Requires a report on or before December 1, 2003 from the Board of Directors of the Maryland Heath Insurance Plan to the Governor and the General Assembly regarding the number of members enrolled in the Plan and the cost to the plan associated with providing insurance to those members for those members enrolled based on their eligibility for the Federal TAA tax credit.	
SB 252 - Health Insurance - Task Force to Study Access to Mental Health Services *Effective date: July 1, 2003*		On or before December 31, 2003, the Task Force shall issue a preliminary report and, on or before December 31, 2004 shall issue a final report, on its findings to the Governor and General Assembly.	The Commissioner must appoint one representative of the commercial health insurance industry, one representative of an HMO, and one representative of a commercial HMO. The MIA and DHMH shall provide staff for the Task Force.
SB 652 - Insurers - Assets and Investments - Location *Effective date: October 1, 2003*	The Commissioner may adopt regulations to implement the changes to § 4-115 of the Insurance Article.		

Bill No. and Title	Regulations	Reports	Task Force
SB 772, HB 1179- Health Insurance - Nonprofit Health Service Plans - Reform		The Maryland Insurance Commissioner shall: (1) determine whether any conduct identified in MIA No: 2003-02-032 violates the provisions of § 14-116 or § 14-139 of the Insurance Article, as in effect before the effective date of this Act, or any other provision of the Insurance Article not identified in MIA No: 2003-02-032; (2) take any action deemed appropriate in light of the determinations made, if any, under item (1) of this subsection; (3) report, on or before July 1, 2003, on the determinations made, if any, under item (1) of this subsection to: (i) the board of directors of a nonprofit health service plan subject to the provisions of § 14-115(d) of the Insurance Article, as enacted by Section 1 of this Act; and (ii) the Governor, and in accordance with § 2-1246 of the State Government Article, the General Assembly; and (4) make recommendations regarding whether any changes to Maryland law need to be made to ensure that the regulatory oversight of nonprofit health service plans subject to Title 14 of the Insurance Article is sufficient to protect the public interest, and report those on or before July 1, 2003, to: (i) the Governor; (ii) in accordance with § 2-1246 of the State Government Article, the General Assembly; and (iii) the Office	

Bill No. and Title	Regulations	Reports	Task Force
		of the Attorney General	
SB 772, HB 1179- Health Insurance - Nonprofit Health Service Plans - Reform		In accordance with § 2-1246 of this title, the committee shall submit an annual report to the General Assembly on or before December 1 of each year. ▪ The report shall include the findings and recommendations of the committee with regard to the examination and evaluation carried out under subsection (f) of this section.	The Maryland Insurance Administration and the Department of Legislative Services, Office of Policy Analysis, shall provide staff assistance to the [Nonprofit Health Service Plan Joint Oversight] committee.
SB 772, HB 1179- Health Insurance - Nonprofit Health Service Plans - Reform		On or before December 1, 2005, and annually thereafter, the Commissioner shall report to the governor and, in accordance with § 2-1246 of the state government article, the Senate Finance committee and the House Health and Government Operations committee, on the compliance of a nonprofit health service plan subject to § 14-115(d) of this subtitle with the provisions of this subtitle.	

Insurance Regulations
July 1, 2001 – June 30, 2003

Life and Health

Chapter Affected: COMAR 31.09.05 Replacement of Life Insurance and Annuities

This action adopted, with some modifications, the most recent version of the NAIC Life Insurance and Annuities Replacement Model Regulation. The action established standards and procedures that insurers and insurance producers are required to follow when engaged in the replacement of existing life insurance policies and annuity contracts.

Effective Date, Permanent Adoption: January 1, 2002

Chapter Affected: COMAR 31.09.05 Replacement of Life Insurance and Annuities

This action brought the regulations into closer conformity with the NAIC Life Insurance and Annuities Replacement Model Regulation.

Effective Date, Permanent Adoption: October 14, 2002

Chapter Affected: COMAR 31.10.06 Standards for Medicare Supplement Policies

This action amended the Medicare Supplement regulations to bring them into compliance with the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act and to implement §15-904 of the Insurance Article, which revised the Medicare Supplement law to permit carriers to sell Medicare Select coverage in Maryland and requires the Insurance Commissioner to adopt regulations to establish the requirements of the Medicare Select Program.

Effective Date, Emergency Status: October 1, 2001

Effective Date, Permanent Adoption: April 11, 2002

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

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

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

Effective Date, Permanent Adoption: September 7, 2001

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

This action made technical corrections and added a benefit covering the cost of hearing aids for children.

Effective Date, Permanent Adoption: March 18, 2002

Chapter Affected: COMAR 31.10.16 Carrier Provider Panels – Application Process

This action altered the manner in which a carrier is required to provide notice of how to apply to the carrier's provider panel.

Effective Date, Permanent Adoption: December 23, 2002

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

This action prohibits a health insurance carrier from excluding coverage for a loss suffered by the victim of a crime.

Effective Date, Emergency Status: May 9, 2003

Effective Date, Permanent Adoption: October 27, 2003

Chapter Affected: COMAR 31.10.27 Health Insurance – Notice of Substantial, Available, and Affordable Coverage

This action implemented §15-606.1 of the Insurance Article, which requires the Insurance Commissioner to adopt regulations that require each carrier in the nongroup health insurance market to notify an individual denied coverage under a medically underwritten plan of the availability of substantial, available, and affordable coverage.

Effective Date, Emergency Status: October 1, 2001

Effective Date, Permanent Adoption: April 1, 2002

Chapter Affected: COMAR 31.10.27 Notice of Maryland Health Insurance Plan

The purpose of this action was to implement §15-1303(c) of the Insurance Article, which requires a carrier that denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market to provide the individual with information regarding the availability of coverage under the Maryland Health Insurance Plan.

Effective Date, Emergency Status: January 1, 2003

Effective Date, Permanent Adoption: January 6, 2003

Chapter Affected: COMAR 31.10.28 Individual Health Insurance Contracts – Standard Provisions and Exclusions

This action established standards for certain provisions, exclusions, and limitations in individual health insurance contracts.

Effective Date, Emergency Status: January 1, 2002

Effective Date, Permanent Adoption: June 10, 2002

Chapter Affected: COMAR 31.10.28 Individual Health Insurance Contracts – Standard Provisions and Exclusions

This action prohibits a health insurance carrier from excluding coverage for a loss suffered by the victim of a crime.

Effective Date, Emergency Status: May 9, 2003

Effective Date, Permanent Adoption: October 27, 2003

Chapter Affected: COMAR 31.10.29 Complaint Process for Coverage Decisions

This action clarified procedures and standards applicable to the complaint process for coverage decisions. The action defined an urgent medical condition that allows a member, or health care provider acting on behalf of a member, to file a complaint with the Commissioner without first exhausting the carrier's internal appeal process. In addition, the action clarified that, in the case of a retrospective denial, an urgent medical condition will not be deemed to exist for purposes of allowing a member or health care provider to file a complaint with the Commissioner without first exhausting the carrier's internal grievance process.

Effective Date, Permanent Adoption: June 10, 2002

Chapter Affected: COMAR 31.11.06 Comprehensive Standard Health Benefit Plan

This action made technical corrections and added a benefit covering the cost of hearing aids for children.

Effective Date, Permanent Adoption: March 18, 2002

Chapter Affected: COMAR 31.11.06 Comprehensive Standard Health Benefit Plan

This action: (1) added a benefit for residential crisis services to the Plan; (2) clarified that coverage of habilitative services for congenital or genetic birth defects includes habilitative services for the treatment of autism and cerebral palsy; and (3) repealed a limitation on the coverage of dental treatment necessitated by accident that was inconsistent with the federal Health Insurance Portability and Accountability Act of 1996.

Effective Date, Permanent Adoption: April 14, 2003

Chapter Affected: COMAR 31.11.10 Required Standard Provisions

This action prohibits a health insurance carrier from excluding coverage for a loss suffered by the victim of a crime.

Effective Date, Emergency Status: May 9, 2003

Effective Date, Permanent Adoption: October 27, 2003

Chapter Affected: COMAR 31.12.07 Required Standard Provisions

This action prohibits a health insurance carrier from excluding coverage for a loss suffered by the victim of a crime.

Effective Date, Emergency Status: May 9, 2003

Effective Date, Permanent Adoption: October 27, 2003

Chapter Affected: COMAR 31.13.03 Standards for Credit Involuntary Unemployment Insurance

This action established regulatory standards for credit involuntary unemployment benefit insurance, including establishing a minimum loss ratio and setting prima facie premium rates.

Effective Date, Permanent Adoption: January 1, 2003

Chapter Affected: COMAR 31.14.01 Long-Term Care Insurance

This action amended the Long-Term Care Insurance regulations to bring the regulations into compliance with the NAIC Long-Term Care Insurance Model Regulation and the NAIC Long-Term Care Insurance Model Act and to revise the regulations to be consistent with Maryland law.
Effective Date, Permanent Adoption: April 1, 2002

Chapter Affected: COMAR 31.14.02 Long-Term Care Insurance – Premium Rates and Reserves

This action amended the Long-Term Care Insurance regulations to bring the regulations into compliance with the NAIC Long-Term Care Insurance Model Regulation regarding long-term care rating and reserving requirements.
Effective Date, Permanent Adoption: April 1, 2002

Property and Casualty

Chapter Affected: COMAR 31.03.06 Surplus Lines

This action clarified the definition of "residential property" with respect to requirements regarding a substantially similar renewal offer and the use of a disclosure form for policies written by a surplus lines insurer that cover residential property. The action also provides that a renewal offer on residential property is presumed to be made on substantially the same terms and conditions as current coverage, unless the renewal offer contains certain terms and conditions. In addition, the action requires a surplus lines broker or an originating producer to include certain information in an affidavit or on a form whenever coverage provided by an authorized insurer on residential property is replaced with coverage provided by an unauthorized insurer. The action also authorizes a commercial insured to waive the diligent search requirement for the procurement of a surplus lines insurance policy that meets certain requirements.
Effective Date, Permanent Adoption: January 7, 2002

Chapter Affected: COMAR 31.08.03 Notices of Cancellation, Nonrenewal, Premium Increase, and Reduction in Coverage

The purpose of this action was to implement Chapter 553, Acts of 2002, which made changes to the law governing notices of premium increase for policies of motor vehicle liability insurance.
Effective Date, Permanent Adoption: January 1, 2003

Chapter Affected: COMAR 31.08.09 Group Self-Insurance for Workers' Compensation

This action: (1) increased the attachment point for reinsurance coverage required to be maintained by a workers' compensation self-insurance group to a level that better reflects the availability of reinsurance under current market conditions; and (2) increased the amount of minimum premium required to be assessed and the amount of the surety bond required to be obtained by a workers' compensation self-insurance group.
Effective Date, Emergency Status: October 28, 2002

Effective Date, Permanent Adoption: February 3, 2003

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

The purpose of this action was to implement Chapter 580, Acts of 2002, which prohibits an insurer from using credit history to underwrite or rate a homeowner's insurance policy, prohibits an insurer from using credit history to underwrite or increase a renewal premium for a private passenger motor vehicle insurance policy, and restricts the manner in which an insurer may use credit history to rate a new private passenger motor vehicle insurance policy.
Effective Date, Permanent Adoption: October 14, 2002

Professional Licensing

Chapters Affected: COMAR 31.03.02 Insurance Agents and Brokers – Continuing Education Requirements
COMAR 31.03.09 Staggered System for Renewal of Certificates of Qualification

This action established a staggered system of renewal for certificates of qualification of agents and brokers.
Effective Date, Permanent Adoption: August 20, 2001

Chapter Affected: COMAR 31.03.10 Advisers

This action established that a person is not required to be licensed as an advisor in order to represent to the public that the person is a member of a trade association or similar organization that uses the term "insurance adviser" or any similar term in the name of the association or organization if the person meets certain requirements.
Effective Date, Permanent Adoption: January 21, 2002

COMAR 31.03.11 Motor Vehicle Rental Companies – Limited Lines License

The purpose of this action was to implement the provisions of Title 10, Subtitle 6 of the Insurance Article by: (1) establishing requirements that an applicant must meet to obtain a limited lines license to sell insurance in connection with, and incidental to, the rental of a motor vehicle; (2) providing for the form and content of the required disclosure to renters; and (3) establishing training requirements for employees of motor vehicle rental companies that sell insurance.
Effective Date, Permanent Adoption: September 1, 2002

Chapter Affected: COMAR 31.03.12 Procedures – Written Consent – Federal Law

This action established procedures and requirements for individuals who are required by 18 U.S.C §1033 to obtain written consent from the Insurance Commissioner before the individuals may engage in the business of insurance in the State.
Effective Date, Permanent Adoption: June 24, 2002

Financial Requirements

Chapter Affected: COMAR 31.05.10 Financial Guaranty Insurance

The purpose of this action was to implement §5-1005 of the Insurance Article by establishing limits on the risk retained by an insurer for a subject of financial guaranty insurance, including requirements for contingency reserves.
Effective Date, Permanent Adoption: September 15, 2003

Chapter Affected: COMAR 31.06.04 Premium Tax – Required Filings, Payments, Penalties, and Interest

This action clarified the manner in which premium tax liability is estimated and paid, requires a person subject to premium tax to make certain filings, and imposes penalties and interest for failure to make certain tax payments or file certain reports.
Effective Date, Permanent Adoption: September 17, 2001

Chapter Affected: COMAR 31.12.02 Managed Care Organizations – Financial Compliance Requirements

This action implemented: §4-311(b)(2) of the Insurance Article and Section 3, Chapter 331, Acts of 2000, which require the Insurance Commissioner, in consultation with the Secretary of Health and Mental Hygiene, to adopt regulations that apply risk-based capital standards to managed care organizations; and §15-102.4(d) of the Health-General Article, which requires managed care organizations to comply with the regulations.
Effective Date, Permanent Adoption: August 20, 2001

Hearings

Chapters Affected: COMAR 31.02.01 Hearings Conducted by the Administration
COMAR 31.02.02 Hearings Conducted by Administrative Law Judges

This action established procedures for requesting and conducting a hearing on an examination report.
Effective Date, Permanent Adoption: February 4, 2002

Chapter Affected: COMAR 31.02.02 Hearings Conducted by Administrative Law Judges

This action gives the Insurance Commissioner discretion, on a case-by-case basis, to delegate to the Office of Administrative Hearings the authority to issue: (1) proposed findings of fact, proposed conclusions of law, and a proposed order; or (2) final findings of fact, final conclusions of law, and a final order.
Effective Date, Emergency Status: May 30, 2003
Effective Date, Permanent Adoption: October 27, 2003

Chapter Affected: COMAR 31.02.06 Procedures for Quasi-Legislative Hearings

This action established procedures for quasi-legislative hearings that the Insurance Commissioner conducts to gather information before making a decision or taking an action.

Effective Date, Permanent Adoption: October 15, 2001

Maryland Health Insurance Plan

Chapter Affected: COMAR 31.17.01 Plan Administrator Criteria

The purpose of this action was to implement §14-506 of the Insurance Article, which requires the Board of the Maryland Health Insurance Plan to adopt regulations that establish criteria for selecting the administrator for the Maryland Health Insurance Plan.

Effective Date, Emergency Status: February 6, 2003

Effective Date, Permanent Adoption: August 4, 2003

Chapter Affected: COMAR 31.17.02 Medically Uninsurable Individual Based on a Medical or Health Condition

The purpose of this action was to implement §14-501 of the Insurance Article, which requires the Board of the Maryland Health Insurance Plan to adopt regulations that specify the list of medical or health conditions that will automatically qualify a Maryland resident as medically uninsurable.

Effective Date, Emergency Status: February 6, 2003

Effective Date, Permanent Adoption: August 4, 2003

Chapter Affected: COMAR 31.17.03 Operation and Administration of the Plan

The purpose of this action is to implement §14-503(j) of the Insurance Article, which requires the Board of the Maryland Health Insurance Plan to adopt regulations necessary to operate and administer the Plan.

Effective Date, Emergency Status: April 8 and July 1, 2003

Effective Date, Permanent Adoption: Pending

Miscellaneous

Chapter Affected: COMAR 31.16.08 Privacy of Consumer Financial and Health Information

This action implemented §2-109 of the Insurance Article, which requires the Insurance Commissioner to adopt regulations that establish standards governing the privacy of consumer financial and health information pursuant to Title V of the federal Financial Services Modernization Act of 1999 (Gramm-Leach-Bliley) and that are consistent with the provisions of the model regulation adopted by the NAIC entitled "Privacy of Consumer Financial and Health Information Regulation."

Effective Date, Permanent Adoption: January 21, 2002

Insurance Bulletins
July 1, 2001 – June 30, 2003

All Bulletins are available on the MIA website,
www.mdinsurance.state.md.us under Insurer Services.

Bulletin 01-11
Issued To: Property and Casualty Insurance Companies
Title Insurance Companies
Rating Organizations
Re: Certification Filing
Date of Issuance: August 2, 2001

Bulletin 01-12
Issued To: Property and Casualty Insurance Companies
Title Insurance Companies
Rating Organizations
Re: Revised Rate and Form Filing Transmittal Form
Date of Issuance: August 2, 2001

Bulletin 01-13
Issued To: Carriers Participating in the Substantial, Available and Affordable Coverage Program
Re: Emergency Regulations COMAR 31.10.27
Date of Issuance: September 10, 2001

Bulletin 01-14
Issued To: Carriers Participating in the Non-Group Health Insurance Market
Re: Emergency Regulations COMAR 31.10.27
Date of Issuance: September 10, 2001

Bulletin 01-15
Issued To: Compliance Officers of Life Insurers, Health Insurers, Health Maintenance Organizations, Nonprofit Health Service Plans, Fraternal Benefit Societies, Dental Plan Organizations, and Third Party Administrators
Re: Producer Enrollment Forms
Date of Issuance: November 14, 2001

Bulletin 01-16
Issued To: All Licensed Insurers, Health Maintenance Organizations, Dental Plans, Nonprofit Health Service Organizations, Surplus Lines Insurers, and Reinsurers
Re: Executive Order Blocking Property and Prohibiting Transactions with Persons Who Permit, Threaten to Commit, or Support Terrorism
Date of Issuance: October 19, 2001

Bulletin 01-17
Issued To: Life and Health Insurers
Nonprofit Health Service Plans
Health Maintenance Organizations
Re: New Colorectal Cancer Screening Mandate
Date of Issuance: November 19, 2001

Bulletin 02-1
Issued To: President, Managed Care Organizations
Re: Risk Based Capital Exemption
Date of Issuance: January 3, 2002

Bulletin 02-2
Issued To: Property and Casualty Insurance Companies
Title Insurance Companies
Rating Organizations
Re: Exclusions Related to Acts of Terrorism – Expedited Filing Procedures
Date of Issuance: January 14, 2002

Bulletin 02-3
Issued To: President, All Licensed Insurance Companies, HMOs, Non-Profits, Dental Plans, MCOs, Fraternal Benefit Societies, etc.
Re: 2001 Premium Tax and Annual Filing Requirements
Date of Issuance: January 17, 2002

Bulletin 02-4
Issued To: Health Maintenance Organizations Participating in the Small Group Market
Re: Contract Filings
Date of Issuance: March 28, 2002

Bulletin 02-5
Issued To: Insurers and Nonprofit Health Service Plans Participating in the Small Group Market
Re: Contract Filings
Date of Issuance: March 28, 2002

Bulletin 02-6
Issued To: President, All Licensed Health Maintenance Organizations and Managed Care Organizations
Re: Implementation of Chapter 323, Acts of the General Assembly of 2000, Downstream Risk Regulation, Quarterly Reviews and Inspections of Downstream Risk Providers
Date of Issuance: April 1, 2002

Bulletin 02-7
Issued To: Property and Casualty Insurance Companies

Re: Disclosure of Practice of Considering Claims History
Date of Issuance: April 1, 2002

Bulletin 02-8
Issued To: Property and Casualty Insurance Companies
Re: Notice of Premium Increase Pursuant to §27-604 of the Insurance Article
Date of Issuance: April 19, 2002

Bulletin 02-9
Issued To: All Life Insurance Companies Licensed to Do Business in the State of Maryland
Re: Flexible Premium Life (UL) and Variable Premium Universal Life (VUL) Policy Forms Containing Long-Term Secondary Guarantees
Date of Issuance: April 11, 2002

Bulletin 02-10
Issued To: Compliance Director, Insurance Companies With Approved Long-Term Care Policies
Re: Notice of Amended Long-Term Care Insurance Regulations
Date of Issuance: April 12, 2002

Bulletin 02-11
Issued To: President, All Domestic Insurance Companies, HMOs, Non-Profits, Dental Plans, MCOs, etc.
Re: USA Patriot Act of 2001
Date of Issuance: April 17, 2002

Bulletin 02-12
Re: Summary of 2002 Insurance Legislation Signed into Law by Governor Parris N. Glendening
Date of Issuance: May 2002

Bulletin 02-13
Issued To: Insurers, Nonprofit Health Service Plans, Health Maintenance Organizations, and Third Party Administrators
Re: Request for Notice of Interest – Maryland Health Insurance Plan
Date of Issuance: June 19, 2002

Bulletin 02-14
Issued To: All Personal Lines Property and Casualty Insurers
Re: Use of Credit History for Underwriting and Rating
Date of Issuance: June 24, 2002

Bulletin 02-15
Issued To: Credit Insurance Companies

Re: Notification of Promulgation of COMAR 31.13.03, Standards for Credit Involuntary Unemployment Benefit Insurance
Date of Issuance: July 30, 2002

Bulletin 02-16
Issued To: All Personal Lines Property and Casualty Insurers
Re: Use of Credit History for Underwriting and Rating
Date of Issuance: August 9, 2002

Bulletin 02-17
Issued To: All Property and Casualty Insurers
Re: Motor Vehicle Liability Insurance – Notices of Cancellation, Nonrenewal, Premium Increase, and Reduction in Coverage
Date of Issuance: August 9, 2002

Bulletin 02-18
Issued To: Health Insurers
Health Maintenance Organizations
Nonprofit Health Service Plans
Managed Care Organizations
Third-Party Administrators
Re: COMAR 31.10.11.14 Uniform Claims Forms ("Clean Claims") Semi-Annual Data Filing
Date of Issuance: September 16, 2002

Bulletin 02-19
Issued To: President, Managed Care Organizations
Re: Risk Based Capital Applicability for 2002
Date of Issuance: September 19, 2002

Bulletin 02-20
Re: Maryland Continuation Coverage: Maintaining Group Health Insurance Benefits After Leaving the Group
Date of Issuance: October 1, 2002

Bulletin 02-21
Issued To: Small Group Carriers
Re: Small Employer Group Health Insurance – Self-Employed Individuals
Date of Issuance: October 17, 2002

Bulletin 02-22
Issued To: All Property and Casualty Insurers
Re: Moratoriums on the Writing of "New" Personal Lines Business
Date of Issuance: October 30, 2002

Bulletin 02-23
Issued To: Private Passenger Automobile Insurers in Maryland
Re: Use of Credit Scoring Models
Date of Issuance: November 1, 2002

Bulletin 02-24
Issued To: President, All Domestic Insurance Companies
Re: Insurer Affiliation Survey
Date of Issuance: November 7, 2002

Bulletin 02-25
Issued To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations With Provider Panels
Re: Credentialing of Providers by a Credentialing Intermediary
Date of Issuance: November 20, 2002

Bulletin 02-27
Issued To: President, All Non-Domestic Insurance Companies
Re: Annual Statement and Annual Audited Financial Statement Filings
Date of Issuance: December 2, 2002

Bulletin 02-28
Issued To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations Participating in the Non-Group Market in Maryland
Re: COMAR 31.10.27 Notice of the Maryland Health Insurance Plan
Date of Issuance: December 20, 2002

Bulletin 03-1
Issued To: All Property & Casualty Insurers Writing Commercial Lines Insurance Products
Re: Voluntary Expedited Filing Products for Compliance with the Provisions of the Terrorism Risk Insurance Act of 2002
Date of Issuance: February 14, 2003

Bulletin 03-2
Issued To: Health Maintenance Organizations
Re: Certification of Medical Directors
Date of Issuance: February 27, 2003

Bulletin 03-3
Issued To: Small Group Carriers
Re: Amendments to COMAR 31.11.06
Contract Filings
Date of Issuance: March 14, 2003

Bulletin 03-4
To: Carriers Selling Medicare Supplement Policies in Maryland
Re: New Guarantee Issue Rights for Certain Medicare Eligible Individuals
Date of Issuance: April 25, 2003

Bulletin 03-5
Issued To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations Participating in the Non-Group Health Market in Maryland
Re: New Telephone Number / Address for Maryland Health Insurance Plan
COMAR 31.10.27 Notice of the Maryland Health Insurance Plan
Date of Issuance: May 15, 2003

Bulletin 03-6
Issued To: All Property and Casualty Insurers
Re: Notice of Premium Increase of 20% or More
Date of Issuance: May 23, 2003

Bulletin 03-7
Re: Summary of 2003 Insurance Legislation Signed Into Law by Governor Robert L. Ehrlich, Jr.
Date of Issuance: May 2003

Bulletin 03-8
Issued To: All Property and Casualty Insurers
Re: §27-605 Notices of Cancellation, Nonrenewal, Premium Increase and Reduction in Coverage for Private Passenger Automobile Policies – Compliance with COMAR 31.08.03.09
Date of Issuance: May 29, 2003

Bulletin 03-9
Issued To: All Property and Casualty Insurers
Re: §27-605 Notices of Cancellation, Nonrenewal, Premium Increase and Reduction in Coverage for Private Passenger Automobile Policies – Compliance with COMAR 31.08.03.09
Date of Issuance: May 30, 2003

Bulletin 03-10
Issued To: All Property and Casualty Insurers
Re: Bulletin 03-6 – Notice of Premium Increase of 20% or More
Date of Issuance: May 30, 2003

Bulletin 03-11
Issued To: Carriers Selling Individual Health Benefit Plans in Maryland
Re: Required Report Regarding Declined Individuals
Date of Issuance: June 20, 2003

Bulletin 03-12
Issued To: All Property and Casualty Insurers
Re: Mold Exclusions
Date of Issuance: June 27, 2003

II. Office of the Commissioner

The Office of the Commissioner is responsible for the coordination and development of policy for the Commissioner. In this role, its operations are concentrated in four main functions:

- Policy Development
- Government Affairs
- Regulations, and
- Communications and Consumer Services

Office of Policy

One of the primary duties of the Office of Policy is to advise the Commissioner on policy matters in a manner that will allow the Commissioner to act on developing issues. Working with other Associate Commissioners, the Office of Policy researches and evaluates upcoming issues related to the regulation of insurance or development of insurance markets, and prepares briefing materials for the Commissioner. It also helps to implement laws and draft regulations with the assistance of the affected Sections of the MIA.

For example, in FY 2002 the Office of Policy supported the Commissioner in his monitoring of the withdrawal by the CareFirst BlueCross BlueShield health maintenance organizations, FreeState Health Plan and Delmarva Health Plan, from the Maryland market. This involved issues such as creating a "home" for those insureds who were displaced, properly informing the affected insureds, rate review, and compliance with the relevant statutes.

Policy Development also continued the implementation of the Clean Claims regulations. Chapter 410, Acts of 2000 charged the MIA with proposing regulations that define a clean claim, including the data elements necessary on the claims forms and the attachments to those forms. In addition, the regulations needed to set forth permissible categories of dispute, as well as standards for receipt of claims. In FY 2002, the MIA continued the Clean Claims Work Group comprised of interested parties and amended the regulations. It also created a form for carriers to submit claims data as required by the regulations.

Policy Development was responsible for the annual submission to the Department of Budget and Management of the MIA's Managing for Results (MFR), an initiative created by the Governor for all State agencies. The MFR sets forth the MIA's goals and its relevant Units' objectives, and uses specific performance measures to gauge its progress toward achieving those objectives.

Finally, in FY 2002 the Associate Commissioner of Policy served as the hearing officer on several contested cases concerning denial of coverage for certain health care

services. Some of these cases involved denial of inpatient hospitalization based on medical necessity, as well as denial of services based on non-coverage for experimental procedures.

Office of Government Affairs

The Office of Government Affairs represents the Insurance Commissioner in matters before the Governor's Legislative Office, the Maryland General Assembly and the Maryland Congressional Delegation, and develops the positions of the MIA on legislation during the Legislative Session of the Maryland General Assembly. This involves evaluating all legislative proposals regarding the business of insurance and making available accurate and relevant information to the Governor and General Assembly in order to assist them in the decision-making process.

The Office of Government Affairs is also responsible for the development of the MIA's proposed Departmental legislative agenda and assists the Legislative Office of the Governor with the development of administration bills that involve insurance. In addition, the Office of Government Affairs evaluates passed legislation for possible veto by the Governor.

During the 2003 Session, the Office of the Commissioner strongly advocated for the passage of several bills, including the following:

- SB252 established a task force to study and make recommendations regarding the mental health care delivery system in Maryland. The Task Force on Mental Health Services is chaired by the Insurance Commissioner’s designee.
- HB499 required the Insurance Commissioner to establish standards governing the processing of claims by an insurer that issues or delivers policies that include a disability benefit. The standards provide an insured with certain rights and protections regarding the handling of a claim for disability benefits.
- HB 656 clarified when a member of an HMO may not be balance billed by a provider for a covered service.
- HB 1100 – Health Insurance Coverage Availability Act of 2003 amended the Maryland Health Benefit Plan to allow individuals such as Bethlehem Steel retirees to be eleigible for certain tax credits as a result of the individual’s participation in the Maryland Health Benefit Plan. In addition, HB 1100 requires a carrier that sells Medigap to issue any Medigap policy the carrier sells in the State to an individual eligible for Medicare under certain conditions.
- SB 722 established certain provisions to ensure that certain nonprofit health service plans licensed in Maryland were operated in a manner consistent with the mission of a nonprofit health service plan.
- SB 658 prohibited an insurer from issuing a policy of life insurance if the policy excludes or restricts coverage for death that is the result of an act of terrorism.

During the 2002 Session, the Office of the Commissioner strongly advocated for the passage of several bills, including:

- HB 521 which greatly restricts an insurer's ability to consider the credit history of an applicant or insured with respect to private passenger motor vehicle insurance and prohibits an insurer from considering the credit history of an applicant or insured as a factor for purposes of underwriting, rating, canceling or renewing a policy of homeowner's insurance, and
- HB 1228 which continues the Senior Prescription Drug Program and establishes the Maryland Health Insurance Plan to provide medically uninsurable individuals with the opportunity to purchase health care coverage.
- HB 1002 which amends current law to require an insurer that provides private passenger automobile insurance to provide to the policyholder certain information concerning the reason for an increase in the policy premium and provide an insured with a notice of the insured's right to protest the premium increase.
- SB 90 which requires health maintenance organizations and managed care organizations to comply with Title 7 of the Insurance Article and enhance regulatory oversight for solvency of HMOs and MCOs.

During the session, the Office of Government Affairs oversees the preparation of fiscal estimates for each insurance-related bill introduced in the General Assembly. Working in conjunction with the staff of the various sections and units of the MIA, the Office of Government Affairs gathers information and prepares an estimate of the fiscal impact each bill will have on the MIA, the insurance industry and the public. The fiscal estimates are given to the Department of Legislative Services, who uses the information to prepare fiscal notes for the General Assembly. During the 2002 Session, fiscal estimates were prepared on 83 bills.

Depending on legislation, the Office of Government Affairs may staff task forces and prepare reports for the Governor and General Assembly that come from legislation. As a result of the Legislative Session, the General Assembly charged the MIA with the studies listed in the charts that follow.

In June of each year, the Office of the Commissioner produces an annual summary of all insurance-related legislation passed by the General Assembly during the past Session and signed by the Governor. This summary is available on the MIA web site, www.mdinsurance.state.md.us.

Regulations

The Office of the Commissioner coordinates and oversees the drafting, proposal, and adoption of regulations by the MIA. In carrying out this responsibility, the Office of the Commissioner works closely with the staff of the various sections and units of the MIA, the staff of the Joint Committee on Administrative, Executive, and Legislative Review, and the staff of the Division of State Documents.

The MIA regularly takes action on regulations to:

- implement legislation enacted by the General Assembly;
- implement the policies of the MIA;
- maintain NAIC accreditation by bringing the MIA's regulations into conformity with the latest model regulations promulgated by the NAIC; and
- update or eliminate obsolete regulations.

During FY 2002 and FY 2003, the MIA completed several major actions on regulations that will provide significant benefits to Maryland consumers.

Credit Involuntary Unemployment Benefit Insurance

Historically, credit involuntary unemployment benefit insurance has been largely unregulated. In Maryland the loss ratio for credit involuntary unemployment benefit insurance for the years 1987 through 1999 was 8.4 percent. During FY 2002, the MIA adopted regulations to establish standards for credit involuntary benefit insurance. The regulations establish prima facie premium rates at levels anticipated to produce a 55 percent loss ratio. This is expected to reduce the amount of premiums charged consumers by approximately 80 percent and save consumers approximately $23.5 million per year.

Replacement of Life Insurance and Annuities

During FY 2002, the MIA adopted, with some modifications, the most recent version of the NAIC Life Insurance and Annuities Replacement Model Regulation. The regulations established standards and procedures that insurers and insurance producers are required to follow when engaged in the replacement of existing life insurance policies and annuity contracts. These standards and procedures are designed to ensure that purchasers of life insurance and annuities receive the information necessary to make an informed decision and reduce the opportunity for misrepresentation and incomplete disclosure. During FY 2003, the MIA made some minor modifications to the regulations to bring them into closer conformity with the NAIC Life Insurance and Annuities Model Regulation.

Written Consent to Engage in the Insurance Business

The federal Violent Crime Control and Law Enforcement Act of 1994 (the Act) requires certain individuals who have been convicted of a felony involving dishonesty, a felony involving breach of trust, or a violation of the Act to obtain written consent from the insurance regulatory authority of a state before the individuals may engage in the business of insurance affecting interstate commerce in that state. During FY 2002, the MIA adopted regulations to implement the Act by establishing procedures for the application for and issuance of a written consent to engage in the business of insurance in Maryland. The regulations established an application process and standards for the review of an application, provide for the grant or denial of a written consent, and require a hearing on the demand of any applicant who is aggrieved by the denial or scope of a written consent.

Motor Vehicle Liability Insurance – Notices of Premium Increase

During the 2002 legislative session, the General Assembly enacted House Bill 1002 (Chapter 553, Acts of 2002), which made extensive changes to the law governing the procedure for premium increases with respect to motor vehicle liability insurance. The changes to the law required the MIA to make extensive changes to its regulations under COMAR 31.08.03 Notices of Cancellation, Nonrenewal, Premium Increase, and Reduction in Coverage. The Office of the Commissioner, working in conjunction with the Consumer Complaints Section and the Property and Casualty Section, completed an extensive revision of the regulations in a short period of time. Among other things, the amended regulations:

- Created notice forms for premium increases of 15 percent or less and premium increases of greater than 15 percent;
- Exempted certain types of premium increases from the notice requirement;
- Clarified the information required to be included in the statement of actual reason for an adverse action due wholly or partly to an accident or violation of a vehicle law; and
- Established record retention requirements for notices of adverse action.

In addition to amending the regulations, the MIA also:

- Held a public meeting to answer questions about the interpretation and implementation of House Bill 1002;
- Issued a bulletin that provides guidance for the implementation of House Bill 1002; and
- Met with representatives of the Office of Administrative Hearings to brief them on the changes to the law made by House Bill 1002.

Credit Scoring

During the 2002 legislative session, the General Assembly enacted House Bill 521 (Chapter 580, Acts of 2002), which prohibits an insurer from using credit history to underwrite or rate a homeowner's risk, prohibits an insurer from using credit history to underwrite or increase a renewal premium for an auto risk, and places restrictions on the manner in which an insurer may use credit history to rate a new auto risk. The changes to the law required the MIA to make extensive changes to its regulations under COMAR 31.15.11 Use of Credit History in Underwriting and Rate Making. The Office of the Commissioner, working in conjunction with the Consumer Complaints Section and the Property and Casualty Section, completed a comprehensive revision of the regulations in a short period of time. Among other things, the amended regulations:

- Defined the term "credit history";
- Clarified the scope of the prohibited and permissible uses of credit history;
- Established a requirement that an insurer that uses credit history to rate a new auto risk advise an applicant on the application form that: (1) the insurer uses credit history; and (2) that the applicant may request a premium quotation that separately identifies the portion of the premium attributable to the applicant's credit history;

- Clarified the steps that an insurer or insurance producer is required to take to determine whether an applicant or insured has any credit history after an initial inquiry fails to generate a credit report, credit score, or other credit history;
- Codified the "best price" rule with respect to the use of credit criteria or a credit score in an insurer's rate-making standards; and
- Established a requirement that insurers that use credit history for rating initial auto risks provide the Insurance Commissioner with the underlying information that the Insurance Commissioner needs to ensure that insurers use credit history in accordance with the standards for rating that exist in Maryland law.

In addition to amending the regulations, the MIA also:

- Held a public meeting to answer questions about the interpretation and implementation of House Bill 521;
- Issued two bulletins that provide guidance for the implementation of House Bill 521; and
- Reviewed the credit scoring models of insurers and third party vendors to ensure that the models comply with House Bill 521.

Privacy of Consumer Financial and Health Information

During FY 2002, the MIA adopted regulations that establish standards governing the privacy of consumer financial and health information pursuant to Title V of the federal Financial Services Modernization Act of 1999 (Gramm – Leach – Bliley) and that are consistent with the provisions of the model regulation adopted by the NAIC entitled "Privacy of Consumer Financial and Health Information Regulation." In addition to establishing privacy standards for nonpublic personal financial information that generally are consistent with federal standards, the regulations also establish privacy standards for nonpublic personal health information. The regulations prohibit a licensee from disclosing nonpublic personal health information about a consumer or customer unless the licensee obtains an authorization from the consumer or customer. This gives consumers and customers the right to protect the privacy of their sensitive health information and prevent a licensee from disclosing the information to an affiliate or nonaffiliated third party.

Other major actions on regulations by the MIA during FY 2002 and FY 2003 included amending the MIA's hearing regulations to establish procedures for requesting and conducting a hearing on an examination report; amending the Medicare Supplement regulations to bring them into compliance with the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act; adopting regulations to clarify the procedures and standards applicable to the complaint process for coverage decisions; adopting regulations to establish a staggered system of renewal for insurance producer licenses; and adopting regulations to implement licensing requirements for motor vehicle rental companies that sell insurance in connection with, and incidental to, the rental of a motor vehicle.

Communications and Consumer Services

The Office of Communications and Consumer Services oversees the external communications of the MIA, including media relations, publications, the website and consumer outreach. This involves:

- Coordinating proactive media relations in the form of news releases, news conferences and editorial board meetings;
- Responding to inquiries from general news media and trade publications;
- Developing, distributing and marketing various consumer guides to the insurance industry and to consumers;
- Maintaining the content of the MIA website: www.mdinsurance.state.md.us;
- Coordinating the MIA's response to Public Information Act requests;
- Visiting counties across Maryland to provide direct assistance and information to consumers;
- Participating in consumer education forums, health information fairs, citizen town hall meetings, and similar events;
- Coordinating speaker's bureau requests for staff to attend various events and provide information/assistance to various industry organizations;
- Developing partnerships with other State and Federal agencies and organizations;
- Providing outreach and education on all types of insurance; and
- Carrying out the requirements of the Patient's Bill of Rights by disseminating information compiled and published by other organizations relating to health insurance.

In FY 2002, the Office of Communications and Consumer Services distributed 14,658 separate pieces of printed material, including brochures and informational materials from the National Association of Insurance Commissioners, the Health Care Financing Administration (now called the Centers for Medicare and Medicaid), the Maryland Health Care Commission and the Maryland Health Care Access and Cost Commission. In FY 2003, 6,864 printed materials were distributed. This number is substantially lower than the previous year because of budget constraints that curtailed community outreach efforts for the year.

In FY 2000, the MIA entered into a partnership with the Comptroller's Office where that office agreed to provide space 16 days a month to an MIA representative at various locations across the State. This representative would meet with consumers to help them file complaints and generally access the services of the MIA. The program was curtailed for several months between FY 2002 and FY 2003 because the budget required the person to be temporarily reassigned to Consumer Complaints and Investigation Section. The program was started again in FY 2003.

Traditionally, representatives of this department have staffed the MIA's educational exhibit at various shows across the State. In FY 2002, the MIA had a display at the Maryland State Fair, Maryland Association of Counties meeting, the Baltimore Women's Show, the Maryland Home and Garden Show and several one-day events. In FY 2003, the MIA staff attended the Maryland Home Show.

The Office of Communications and Consumer Services works throughout the year to improve the design, layout and function of the MIA website to provide more comprehensive information in a user-friendly format. Special "pages," are created on the site as news events warrant. An example of this were the more than 85,000 pages of conversion proposal documents placed on the web site, accessed via a special CareFirst Blue Cross BlueShield Conversion page.

In FY 2002 and FY 2003, this department planned and coordinated hearings for the Commissioner on the proposal by CareFirst BlueCross BlueShield to become a for-profit health care company. Eight Opportunities for Public Comment were held in seven locations across the state where more than 250 citizens testified, 15 days of quasi-legislative hearings were held in the Baltimore metropolitan area, and a news conference was held on March 5, 2003 in Annapolis where the Commissioner announced his decision. A total of 17 news releases were issued between January 14, 2002 and the end of March 2003 concerning CareFirst.

III. Office of the Attorney General

The Office of the Attorney General (OAG) acts as the chief legal advisor and counsel to the Insurance Commissioner. The Office consists of a Principal Counsel, who is an Assistant Attorney General (AAG), and additional AAGs as necessary to meet the MIA's needs, including those assigned to the Insurance Fraud Division. Currently, the MIA has a Principal Counsel, a Deputy Counsel, seven AAG positions within the main office of the MIA and three AAG positions within the Fraud Division.

Legal Advice

The OAG advises the MIA regarding the proper interpretation and application of the laws and regulations enforced by the agency. The OAG provides both formal and informal, written and verbal advice on a broad range of subjects, including: the powers, jurisdiction, and authority of the MIA; the licensing, certification, and registration of regulated entities; the regulation of impaired entities and the institution of conservatorships or receiverships; investments; premium tax assessments; the acquisition of domestic insurers; the oversight of insurance professionals, including insurance producers; form and rate filings; the analysis of coverage and claims determinations by carriers on all lines of insurance; premium finance arrangements; the enforcement of the Unfair Trade Practices Act, including prohibitions against unfair methods of competition, unfair claim settlement practices, fraudulent insurance acts, and discrimination; and the enforcement of the Appeals and Grievance laws relating to the denial of health care services.

The OAG assists the MIA in identifying and resolving gaps in existing law and regulation and in developing and drafting legislation, regulations, and advisory bulletins. Pursuant to Section 10-107 of the State Government Article, the OAG is required to review and approve for legal sufficiency all regulations proposed by the MIA. A similar review is made of all legislation proposed on behalf of the MIA and all bulletins issued by the MIA. The OAG also reviews and comments on legislation proposed by third-parties that impact the regulation of insurance.

The OAG assists in the preparation of, and reviews for legal sufficiency, all Requests for Proposals and other procurement-related documents and materials used by the MIA. The OAG also drafts and/or reviews all contracts or contract amendments or change orders made by the MIA, and represents the MIA in connection with the resolution of disputed issues with vendors.

In connection with its advice functions, the OAG also:

- Reviews the MIA's Orders and assists the MIA in analyzing and reviewing for legal sufficiency and correctness, insurance related transactions that require the Commissioner's approval, including the acquisition, merger, transfer, affiliation or conversion of insurance companies and health plans

- Keeps the MIA informed of relevant changes in case law, federal statutory law, and the law of other jurisdictions
- Assists the MIA in its general operations, including the resolution of personnel issues
- Assists the MIA in complying with requests made under the Public Information Act
- Responds to requests for information and legal analysis by other state agencies, legislators, and citizens, including maintaining an attorney-on-call to handle inquiries regarding insurance regulatory issues
- Drafts, reviews and/or approves educational and informational material developed by the MIA
- Participates in working groups sponsored by the National Association of Insurance Commissioners that relate to legal issues.

Litigation/Enforcement

The OAG represents the MIA before State and Federal courts and in administrative hearings with respect to any matters pertaining to decisions made by the MIA. The litigation work performed by the OAG ranges from enforcing and defending orders issued by the MIA for violations of the Insurance Article by licensees, to defending the legality and constitutionality of statutory law and regulations, to establishing receiverships of insolvent entities, to enforcing premium tax assessments.

The OAG works closely with the MIA's two enforcement units: the Compliance and Enforcement Section and the Consumer Complaint Investigation Section. In appropriate cases, the OAG assists these Sections in the investigation and evaluation of whether the conduct of a licensee was unlawful. The OAG reviews in advance all Orders proposed by Compliance and Enforcement Section, as well as all determinations made by the Consumer Complaint Investigation Section that are subject to administrative hearings.

A large segment of the OAG's work in enforcement involves actions against insurance Producers. The OAG works with the MIA's investigators to identify and respond to fraudulent or illegal conduct by Producers. The OAG assists in the gathering of evidence sufficient to warrant, and to sustain, regulatory action, including the summary suspension of licenses. The OAG then pursues the regulatory action through the administrative and judicial process on behalf of the MIA. The OAG frequently coordinates with other State and Federal regulatory agencies on joint enforcement activities and investigations.

A second, substantial area of litigation involves the defense of MIA orders which result in legal action on behalf of policyholders or claimants. For example, the Appeals and Grievance Unit responds to complaints that requests for health benefits believed to be medically necessary were improperly denied. These matters are reviewed on an

expedited basis and the OAG represent the MIA in administrative hearings and on Judicial Review of Order requiring the licensee to provide the benefit.

Litigation relating to enforcement frequently requires the OAG to address Federal law issues, including, for example, the impact of ERISA on state regulatory action.

Receiverships

The OAG represents the MIA in establishing regulatory control, including the institution of receivership proceedings, over financially impaired entities. The OAG frequently represents the MIA as Receiver in marshaling the assets of insolvent entities, establishing and processing claims, and distributing those assets.

The Maryland Health Insurance Plan

The OAG serves as counsel to the Maryland Health Insurance Plan, which was established by legislation in 2002 and which became operational July 1, 2003. MHIP is the State's high risk pool. The OAG counsels the Board and drafts/reviews MHIP's operational and formative documents, as well as its requests for proposals and third-party contracts.

Litigation Highlights FY 2002

- *MIA v. United Healthcare.* The MIA issued an Order in 1999 requiring United Healthcare to pay claims of providers who had not been paid by the HMO's "downstream risk provider." Their downstream risk providers ceased business, leaving approximately $15 million in unpaid provider bills. Several providers and provider groups intervened in support of their right to have claims paid. The contractual relationship between the HMO and the providers ultimately determined who was entitled to payment pursuant to the statute. The Circuit Court for Baltimore City affirmed the MIA's Order, which held that United Healthcare was ultimately responsible for paying claims, even if payment had been previously made to the downstream risk providers. Dimensions and Mercy Medical, two large provider groups, were not entitled to payment by virtue of their relationship to the downstream risk provider, *i.e.*, a shareholder, employee or partner. Their combined claims totaled approximately $5 million. United did not appeal and paid approximately $14,520,000.00, including interest, to providers, thereby resolving tens of thousands of unpaid claims. Dimensions and Mercy Medical did file an appeal, the result of which is reported in Litigation Highlights for FY 2003.

- *MIA v. DHC Title.* – After a four day hearing and exceptions, the Commissioner issued a Final Order revoking a title insurance producer's license for conducting fraudulent flipping transactions. In addition, the agent's employer accepted a nine month suspension for failing to properly supervise the agent and the agency paid a

$25,000 fine for being the vehicle through which the agent conducted the fraudulent transactions. The agent has appealed the Commissioner's Order to the Prince George's County Circuit Court which denied the agent's request for a stay.

- *MIA v. William R. Schinnerer.* – In an unreported opinion, the Court of Special Appeals upheld the Commissioner's Final Order suspending the license of an insurance producer for two years. The agent collected premiums on behalf of the insurer and was authorized to commingle these funds with his operating accounts. Although authorized to hold these funds for a period of time and to retain any interest earned on the premiums during that time, the Court determined that the agent did not have *carte blanche* to use the funds while they were in the agent's possession. Instead, according to the Court, the Commissioner correctly determined that the agent held the premiums as a fiduciary and his use of the premiums prior to the remitting them to the carrier was a misappropriation of funds.

- The Office of the Attorney General provided advice to the Insurance Commissioner, who was acting in the capacity of Receiver of a title insurance agency. The agency was placed into receivership after it defrauded consumers and creditors by misappropriating settlement funds held in escrow. The Office assisted the Insurance Commissioner in reporting to the Circuit Court for Baltimore City on the efforts to recover assets for the benefits of defrauded consumers and creditors and identify valid claims against the title insurance agency. The office also represented the Insurance Commissioner in Baltimore City Circuit Court and obtained Court approval for the Insurance Commissioner's recommendation to begin payment of claims to consumers and creditors that sustained financial harm as a result of the misappropriation of funds.

- The Office of the Attorney General also provided advice to the Insurance Commissioner, who was acting in the capacity of Receiver of a property and casualty insurance agency. The agency was placed into receivership after it defrauded consumers and creditors by fraudulently financing insurance policies and misappropriating premium funds advanced by consumers and premium finance companies. The Office represented the Insurance Commissioner in U.S. Bankruptcy Court for the District of Maryland and obtained the dismissal of the bankruptcy case filed by the insurance agency, permitting the Insurance Commissioner to place the agency into receivership. The Office represented the Insurance Commissioner in Baltimore City Circuit Court and obtained a Court Order placing the agency into receivership and appointing the Insurance Commissioner as Receiver. The Office also succeeded in obtaining Court approval of the sale of the agency's largest asset.

- *MIA v. Tifco* – The OAG negotiated a settlement resulting in the return of $180,000 to Maryland consumers from a premium finance company. The company had collected payments on premium finance agreements which were not supported by the insurance policies identified on the agreements.

- The Office of the Attorney General represented the Insurance Administration before the Office of Administrative Hearings in an appeal of the Administration's determination in seven consumer complaint cases against an auto insurer. The complaints alleged that the insurer's decision to non-renew and/or exclude certain drivers from coverage was in violation of Maryland's insurance laws. The Office obtained a Final Order from the Administrative Law Judge upholding the Administration's determination in all seven cases. The ALJ found that the insurer had improperly considered an automobile accident resulting in a traffic citation as two underwriting incidents instead of one. As a result of this decision, the insurer withdrew three requests for hearings to contest the Administration's determination in three other similar consumer complaints and has agreed to stop double counting single at-fault automobile accidents.

- The Office of the Attorney General represented the Insurance Administration in a complaint hearing concerning the non-renewal of a professional liability policy for a medical doctor in *MIA v. Medical Mutual Insurance Society of Maryland*, MIA 96-2/01. Although Medical Mutual had a filed rate for the coverage, the insurer determined to non-renew the medical doctor. It was this non-renewal that initiated the complaint to the MIA. A petition for judicial review has been filed and it is scheduled for hearing in January 2003.

- Originally argued in September 1996, the Administration issued the final order in *MIA v. Aetna*, MIA 1035-7/99, in July 2002. The Aetna matter was one of the first A&G cases argued and involved an attempt by a carrier to restrict access to mental health services. In addition to the carrier's contract based argument, the carrier argued that Maryland's Utilization Review statute is preempted by ERISA. That argument was rejected by the Administration upon the issuance of the Connecticut General/CIGNA final order in which the Commissioner found that ERISA did not preempt Maryland's insurance laws. This case is presently before the Circuit Court for Baltimore City and has not been scheduled for hearing.

- *MIA v. Interstate Auto Insurance Company (Ex rel.* Bert Daniel). The MIA recovered approximately $2,300 for this insured. The licensee argued that the complainant did not have an insurable interest in the car, which still had the dealer tags. Licensee also argued that since the dealer's insurer paid for the property damage then sought reimbursement from the complainant, this was a third party claim and MAIF was the responsible carrier. A judge of the Circuit Court for Baltimore City as well as a three-judge panel in an En Banc review agreed with the MIA and affirmed on all counts.

- The Office of the Attorney General gave advice in matters that involve medical necessity denials that overlap with contract issues. For example, the Administration received complaints that speech therapy claims were being denied. The Office of the Attorney General discovered that the carrier in question had not updated its contracts to include this as a benefit. The Appeals and Grievance Unit sought advice concerning multiple complaints over speech therapy services for children. Rather

than conduct traditional utilization review, the carrier instead outright denied it as an excluded benefit. In meeting with them and participating in conference calls with the various parties, it became clear that the carrier had failed to update its contracts to include this mandated health benefit. The Office of the Attorney General reviewed the policy forms and noted other omissions, triggering a review of the mandated health benefits which is presently on going. In the end, the carrier paid the speech therapy services involving all the complaints and agreed to make changes to its health benefit plans.

Litigation Highlights FY 2003

- *Larsen v. Chinwuba*, 377 Md. 92 (2003)- This case confirmed that the Maryland Insurance Commissioner is entitled to statutory immunity from liability for allegedly defamatory statements made by him in connection with the public expression of concern over the solvency of a HMO as to which receivership proceedings were instituted.

- *Dimensions Health Corp. v. Maryland Ins. Admin.*, 374 Md 1 (2003) - This case involved the responsibility of an HMO to pay provider claims on behalf of their defunct administrative service providers (ASP). United Healthcare of the Mid-Atlantic (an HMO) had contracted with certain ASPs which, in turn, contracted with health care providers to provide care to United's HMO members. The ASP ceased operations, leaving approximately $15 million in unpaid health care provider claims. The MIA ordered United to pay the claims of most of the health care providers. The claims of Dimensions Health Corporation and Mercy Medical Center were exempted from that requirement, however, because of their corporate relationship to the ASP that had ceased operations. The MIA's determinations were affirmed in the Circuit Court and by the Maryland Court of Appeals.

- *Insurance Comm. v. CareFirst of Maryland, Inc.*, 149 Md.App. 446 (2003) - This case affirmed the MIA's method of analyzing the necessity and adequacy of rates proposed by a nonprofit health plan. Specifically, the Court of Special Appeals affirmed the MIA's consideration of discounts that CareFirst received in hospital rates for SAAC enrollees in determining the propriety of rate increased proposed for other products.

- *Connecticut Gen. Life Ins. Co. v. Ins. Comm*, 371 Md. 455 (2002) - The landmark case concluded that Maryland's Appeals and Grievance and Unfair Claims Settlement Practices laws, as applied to group health plans, are not pre-empted by ERISA.

- *Schinnerer v. Maryland Ins. Admin.* 147 Md.App. 474 (2003) (*cert. denied)* - This case affirmed the MIA's two-year suspension of an agent who did not properly segregate premiums collected on behalf of an insurer, used those premiums for his own business purposes, entered into a loan agreement and payment plan with the insurer to repay the premium, and then failed to honor that loan agreement. The

Court of Special Appeals upheld the principal that an insurance producer, as a fiduciary, has a duty to hold premiums collected on behalf of carriers in trust and may not co-mingle or use those monies without the advance permission of the carrier.

- *MIA v. DHC Title* - After a four day hearing and exceptions, the Commissioner issued a Final Order revoking a title insurance Producer's license for conducting fraudulent flipping transactions. The agent's employer accepted a nine month suspension for failing to properly supervise the agent and the agency paid a $25,000 fine for being the vehicle through which the agent conducted the fraudulent transactions. The agent appealed the Commissioner's Order to the Prince George's County Circuit Court that denied the agent's request for a stay.

Summary of Activity FY2002		
Advice Requests		143
Enforcement Results From Consumer Complaints		247
Agent Enforcement		55
License Denials		8
Appeals/ Grievance		67
Cease/ Desist		2
Market Conduct		19
Miscellaneous consisting of:		79
Life & Health	35	
Examination & Auditing	6	
Policy	1	
Tax Court Appeal	1	
Petitions for Judicial Review	36	
Total		**620**

Summary of Activity FY 2003	
Advice Requests	316
Enforcement Results From Consumer Complaints	150
Agent Enforcement	63
License Denials	0
Appeals/ Grievance	93
Cease/Desist	0

Market Conduct		38
Miscellaneous consisting of:		
Life & Health	29	117
Examination & Auditing	41	
Policy	1	
Tax Court Appeal	0	
Petitions for Judicial Review	38	
Fraud	1	
Subpoena	5	
Personnel	1	
Bankruptcy	1	
Total		**777**

IV. Office of the Chief Actuary

In FY 2002, the Office of the Chief Actuary (OCA) was responsible for actuarial activities related to all lines of business in both the Life & Health and Property & Casualty insurance areas. The Life & Health actuaries reviewed rate filings from health insurance carriers and HMO's, completed the annual valuations of life companies domiciled in Maryland, issued Certificates of Valuation to assure that companies retain adequate funds to pay future claims, and provided expertise for financial examinations of insurance carriers as scheduled by the MIA. The Property & Casualty actuaries similarly reviewed rate filings from property-casualty carriers for both personal and commercial lines of business.

In FY 2003, the Property & Casualty actuaries were transferred to the P&C Section.

The OCA staff includes actuaries who are members of professional actuarial organizations such as the Society of Actuaries (FSA) and the American Academy of Actuaries (MAAA). The OCA provides actuarial support to other units throughout the MIA, and in doing so, also participates in various MIA efforts to provide quality insurance regulation in Maryland.

Reviewing Rate Filings for Various Insurance Coverages

Rate filings from all types of insurance entities are reviewed for appropriate supporting data and justification, adherence to professional actuarial standards, and compliance with Maryland laws and regulations. During FY 2002, the OCA staff reviewed 747 health insurance rate filings from commercial carriers, HMO's, and Blue Cross Blue Shield plans as well as 2,102 property and casualty rate filings ranging from automobile to homeowners to workers compensation insurance.

In FY 2003, the OCA staff reviewed 516 health insurance rate filings from commercial carriers, HMO's, and Blue Cross Blue Shield plans.

Assisting with Financial Examinations of Insurers

The Office of the Chief Actuary assists the Examination and Audit Section of the MIA with required periodic financial examinations of life insurers domiciled in Maryland. The OCA staff handles the actuarial aspects of these examinations and helps to determine appropriate regulatory responses. Examination fees paid to the MIA for actuarial work totaled $1,280 for FY 2002.

Also as required by law, the OCA staff evaluates reserves and other specific items from the annual financial statements of domestic life insurance companies. This actuarial

evaluation of reserves is performed annually to assure that companies retain adequate funds to pay future claims and is based on requirements and standards of Maryland law and regulatory practice.

Analyzing Industry Experience Results and Trends

Responsibilities of The Office of the Chief Actuary include:

- Monitoring rating practices in the small group market for employers with less than 51 employees and publishing a *Health Carriers for Small Employers* (with sample premiums) brochure for consumers each January and July.

- Collecting data from carriers and preparing estimates of the number of Maryland lives generally covered by health insurance.

- Collecting health insurance data and evaluating it for carrier compliance with loss ratio standards in Maryland.

- Until the end of FY 2002, handled the annual automobile insurance data collection as required by the Insurance Reform Act of 1995 from all carriers that write private passenger insurance in Maryland.

- Until the end of FY 2002, handled the annual data call on residential property insurance as required by 1999 Legislation (House Bill 44) from all carriers that write such coverage in the state of Maryland.

Special Efforts with Consumer Complaints, Legislation and Regulations, and Industry Groups

The Office of the Chief Actuary regularly assists with the resolution of consumer complaints and inquiries that often involve insurance pricing and rating issues. OCA personnel also participate in regulatory meetings of the NAIC and serve on an AAA Committee on Actuarial Public Service. The OCA assists in the evaluation, drafting, and implementation of Maryland insurance laws and regulations.

V. Management Information Systems

The Management Information Systems Unit (MIS) provides automation expertise including infrastructure design, computer network support, and application development.

Technology initiatives completed in FY 2002

- **Web site –** Significant advances were implemented in FY 2002 to provide the citizens of Maryland the means to make informed insurance decisions and to provide automated services to the business community.

Implemented Changes to On-Line License Renewals

In 2001, the General Assembly enacted SB576, the Insurance Producer Licensing Act that became effective on July 2, 2001. This Act replaced separate agent and broker licenses with a single Producer license in order for all states to meet the reciprocity requirements of the Federal Gramm-Leach-Bliley Act (GLBA). In accordance with the legislation, the MIA converted its Producer Licensing application to reflect these changes. In its initial year of on-line application, 85 percent of the 60,000 renewals used the on-line renewal system. The remainder filled out the form on line then downloaded it and mailed it in. Fifty percent paid for their licenses on-line by credit card making nearly $2 million dollars immediately available to the MIA via the credit card process. In addition, licenses are now staggered over a three-year period, providing an equalized flow of funds.

Implemented an On-Line Company License Renewal Application

In order to improve the method of getting a Producer license, the MIA developed an application to provide an on-line means to apply and pay for a renewal and get an immediate approved response. The on-line system reduces the manual labor required at the MIA to enter individual company renewal information. Companies benefit because renewal time is reduced from weeks to minutes. This application compliments the ability for companies to file their Premium Taxes on-line that was implemented last year.

Implemented Public Access to Company and Producer Records

Citizens now have access via the MIA web site to significantly more public information on insurance companies and their producers. In order to find the company that currently holds a policy, a consumer can access information on companies that are no longer in existence or have merged with or been purchased by another company.

Implemented On-Line Complaint Form

Previously, the more than 20,000 complaints received each year by the MIA were received in written form. An on-line complaint form was developed to reduce the manual labor required to enter complaint information and the time delay involved when someone files a complaint. An on-line complaint form will be integrated with the new ECTS Complaints System when development is completed. Complaints received from the on-line form will be automatically loaded to the new Complaints System and assigned to an investigator once it has been determined to be a valid complaint. Although health related complaints still require a signature of the complainant, the form completed on-line can be downloaded then signed and mailed.

Implemented New Web Content Manager

This web tool allows the Office of Communications and Consumer Services dynamic control of much of the web site's content.

Fulfilling the Electronic Government Initiative
As per the State mandate to provide services electronically to the citizens of Maryland, in FY 2001, 87% of the MIA's services were available to the public through the web site. In FY 2002, that number increased to 99% of available services available on-line.

- **Enterprise System**

  Implemented Premium Tax Automated Audit
  The Premium Tax application insures that the State is collecting all the revenue it is owed in a timely manner. Use of the new audit software for the first tax year added more than $5 million to the General Fund. For the first time, with the ability of the MIA to charge interest and penalties across the board, an additional $800,000 was billed.

  Implemented Company History Database
  A company history database was created to track companies that may have merged with other companies, been purchased by another company, or which are no longer in existence. Input of this information is from card files that have been kept since the MIA came into existence in the 1800's. Though not completed yet, a substantial amount of information has been cataloged. Once completed, there will be a comprehensive history of insurance companies in Maryland. This feature has been added to the public access query on the MIA's web site.

- **Operations -** MIS support staff created formal operational tasks for security, integrity, and system performance. These tasks are performed on a recurring, systematic basis. Operational tasks address many of the items noted from the 2001 IT audit.
  - Transported archive tapes daily between the Insurance Fraud Division and the main facility
  - Tested archive tapes (domain controllers only)
  - Performed desktop audits and inventory examinations
  - Enabled network auditing (internal accounts only)
  - Strengthened domain accounts
  - Evaluated (implemented) service patches for servers, as necessary
  - Developed cursory disposal procedures
  - Evaluated system logs on key domain servers
  - Gathered daily performance characteristics on key domain servers
  - Maintained MIA computer access control and account security
  - Completed documentation revisions for key domain servers
  - Inspected for occurrences of intrusions or account misuse

- **Support**
  - Addressed 2,719 calls for technical support from MIA staff members
  - Handled 94 Requests For Service (RFS)
  - Deployed new e-mail system agency-wide
  - Shut down NetWare infrastructure components
  - Upgraded Mac desktop publishing station
  - Implemented permission changes for PRA system
  - Deployed additional resources for SERFF system
  - Implemented remote access capability for MIA's field examiners
  - Modified field examiners laptops for a new ISP

- Replaced 30 percent of the MIA's desktop computers
- Deployed new computers for ASI service users
- Created email for Certificates of Authority
- Installed and configured file converters for Commissioner's office and Attorneys General
- Relocated office equipment
- Upgraded Maptitude demographic program
- Deployed TeamMate groupware product
- Updated NAIC electronic library components
- Implemented new servers: two remote access servers, one new backup domain controller, one new CTS server, one new Query server, two new Enterprise servers
- Installed Java plug-in updates agency-wide
- Conducted more than 30 internal training sessions with MIS staff, covering 1,500 pages of technical material and 52 lab exercises
- Addressed and contained significant volumes of incoming email infected with Klez virus; hardened MIA's firewall to prevent usage by spammers
- Provided answers, insights, and material to the IT auditor from the Office of Legislative Auditors

Technology initiatives completed in FY 2003

- **Case Tracking -** Approximately 900 orders are issued each year by the MIA. Final Orders will be available on the agency's web site in 2004 as part of the public access initiative. A new case tracking system links all departments that issue orders through a common application that identifies the status of an order and its resolution. This new system will help the NAIC in its automated electronic updating of regulatory databases.
- **Initial Producer Licensing** – When the MIA made the decision to bring back in-house the Producer Licensing function there was a need to develop Enterprise Initial Licensing and On-line Initial Licensing applications with interfaces to the NAIC to provide national data on Producers. This project was implemented on December 1, 2003.
- **Rates & Forms Initiative** - Funding was approved to integrate a Rates & Forms system into the Enterprise system. Requirements are being created with implementation of the application expected by July 2004. The new application will give companies the ability to file new rates and forms on-line.
- **Compliance & Enforcement** - Through the consolidation of the Market Conduct and Enforcement Units in August 2002, the three individual systems previously updated by an outside vendor could be consolidated into the Enterprise system. The development of this new function will allow the combination of the Market Conduct, Enforcement and Fraud applications, while Licensing Compliance remains part of the Producer Licensing application.
- **Implemented New Reporting Software -** Crystal Enterprise, a web-based reporting system, was implemented this year to provide an end-user friendly reporting system. It will be integrated into the MIA's web based applications.
- **Support -** Additional MIS Development and Infrastructure personnel were added to support all applications, databases, website, and infrastructure in-house, reducing the need for contractual support.

Fulfilling the Electronic Government Initiative

In FY 2003, the MIA continued to have 99 percent of its services available on-line.

- **Operations -** MIS support staff continued monitoring the tasks outlined for FY 2002 from the 2001 IT audit. As a result of the attention to computer operations, MIS support staff provided commendable levels of computer system availability.
  - Network Availability 99.6 percent
  - Production System Availability 99.9 percent

- **Support -** The six members of MIS' support staff addressed 2,051 calls for support.

- **Projects** - MIS support staff were involved in numerous projects planned and initiated within the department during calendar year 2003. In addition, MIA staff received 103 Requests For Service (RFS), with 97 RFS completed.

MIS support staff addressed the following projects during this period:
- Setup two high capacity printers in Producer Licensing
- Deployed 15 computer workstations in Producer Licensing
- Enabled ftp for PLS to allow transfer of Continuing Education data from Experior
- Setup two IVR servers for Producer Licensing
- Setup two Crystal Enterprise servers
- Setup three Jaguar servers
- Relocated office equipment
- Deployed 52 computer workstations in Complaints
- Deploy 13 computer workstations for Attorneys General
- Setup Pitney-Bowes package tracking system in the mailroom
- Provided support for leave tracking system in Personnel
- Supported deployment of ECTS in Complaints
- Enabled evaluation of actuarial valuation software
- Setup 10 computer workstations, VPN, browsing, and cabling changes to facilitate the Hurricane Isabel Victims Citizens Group
- Setup Para-Docs appliance and computer station to allow public access to Property & Casualty's imaging records
- Evaluated Microsoft Server 2003 operating system software

- **Other -** Aside from operations, support, and projects, MIS' support staff addressed other significant requirements.
- Recruited three new staff for computer support group
- Conducted 14 internal training sessions with MIS staff, covering 600 pages of technical material
- Diagnosed a compatibility problem between one Enterprise Server and Sybase's Adaptive Server
- Addressed and contained significant outbreak from Nachi virus

VI. Administrative Section

The Administrative Section was created in FY2002 to oversee Producer Licensing, Fiscal and Support Services, Personnel, and Training and Facilities Management. In addition, this Section coordinates the Managing for Results (MFR) activities for the Insurance Administration.

Producer Licensing Unit

Up through FY 2002, the Producer Licensing Unit consisted of Licensing and Licensing Compliance and Investigation. This Unit investigated and licensed agents and brokers, now called producers, and other insurance professionals and monitored their Continuing Education requirements. In FY 2003, Licensing Compliance and Investigation was spun off to join the new Compliance and Enforcement Section.

Licensing

Licensing is responsible for administering the qualifying examinations for producers, insurance advisers and public adjusters. Licensing issues licenses to qualified resident and nonresident producers, including corporations, partnerships and limited liability companies. Licenses are also issued to individuals and corporations, partnerships and limited liability companies applying to be surplus lines producers. Individual licenses are issued to public adjusters, insurance advisers and motor club representative applicants.

Licensing is responsible for:

- Processing and issuing all types of initial insurance professional licenses,
- Issuing Letters of Certification or Clearance for Maryland resident producers applying for licenses in other states,
- Implementing Continuing Education requirements,
- Renewing of all types of insurance professional licenses.

Beginning in 1997, processing of all license application forms, all requests for Letters of Certification and Clearance, and all appointment filings has been done by Assessment Systems, Inc. (ASI), now called Promissor, a private corporation under contract with the Insurance Administration. ASI also administered qualifying examinations for various licenses. (Although that contract terminated on December 31, 2003, Promissor continues to administer qualifying examinations for various licenses.)

Beginning with the 2001 license renewal period, the MIA began to streamline its licensing processes by offering on-line renewal services and staggering the license expiration dates. After termination of its licensing services contract with Promissor, the MIA will be taking back its licensing services. When that happens, the MIA will, for the first time, provide for the processing of all its insurance professional lines on-line.

The General Assembly enacted legislation that became effective on July 2, 2001 to convert all of the current agent and broker licenses to a single producer type license.

This legislation made it easier for resident licensees to obtain non-resident licenses in other states that have adopted a similar producer licensing law.

To accomplish the task of bringing the licensing services back in-house and streamlining those services, the General Assembly passed legislation in the 2003 Session that removed the requirement that insurers report their appointments to the MIA. In addition, the law was amended to implement the outsourcing of Continuing Education services.

Licensing Compliance and Investigation (spun off to the Compliance & Enforcement Section in FY 2003)

The Licensing Compliance and Investigation Unit's (LCIU) primary responsibility was to conduct background investigations on applicants for producer licenses whose responses to application screening questions indicate further investigation is warranted. In addition, LCIU conducted investigations on those individuals who request a written consent to engage in the business of insurance pursuant to 18 U.S.C. § 1033 and 1034.

In FY 2002, ASI forwarded applications to the Unit for investigation. The investigations were the result of disclosure by the applicant of a criminal conviction, action taken against a professional license, or bankruptcy, except for personal bankruptcy. Investigations were initiated regarding miscellaneous violations.

Licensing Activity – FY 2002

Licenses – Original Issuance		
Type of License	**Number Issued**	**Fees Collected**
Producers (Agents/Brokers)	16,970	$848,500
Surplus Lines Producer	38	$7,600
Temporary	274	$6,850
Insurance Adviser	12	$2,400
Public Adjuster	3	$150
Motor Club	289	$1,445
Third Party Administrator	29	$7,250
Total	**17,615**	**$874,195**

Licenses – Renewals		
Type of License	**Number Issued**	**Fees Collected**
Producers (Agents/Brokers)	23,700	$1,540,500
Surplus Lines Producer	240	$31,200
Adviser	188	$37,600
Public Adjuster	39	$1,950
Third Party Administrator	201	$5,025
Total	**22,368**	**$1,616,275**

Producer (Agent) Appointments		
Type	**Number Issued**	*** Fees Collected**
Original (Paper Appointments)	38,316	
Original (Electronic Appointments)	94,933	
Total	133,249	$1,998,735
Termination (Paper)	29,106	
Termination (Electronic)	13,782	
Total	42,888	$214,440
Appointment and Terminations		
Total	**176,137**	**$2,213,175**

*** Beginning on July 1, 2002, no fees are charged for appointments or terminations**

Producers (Agent/Brokers) Examinations/Continuing Education		
	Number Administered	**Fees Collected**
Examinations	8,428	$210,700
	Number Approved	**Fees Collected**
Continuing Education Courses	2,337	$116,850

Licensing Activity – FY 2003

Licenses – Original Issuance		
Type of License	**Number Issued**	**Fees Collected**
Producers (Agents/Brokers)	17,277	$932,958
Surplus Lines Producer	88	$17,600
Temporary	327	$8,829
Insurance Adviser	12	$2,400
Public Adjuster	31	$1,550
Motor Club	590	$2,950
Third Party Administrator	33	$8,250
Total	**18,358**	**$974,537**

Licenses - Renewals		
Type of License	**Number Issued**	**Fees Collected**
Producers (Agents/Brokers)	22,525	$1,554,225
Surplus Lines Producers	270	$54,000
Adviser	191	$38,200
Public Adjuster	70	$3,500
Third Party Administrator	208	$10,400
Total	**23,264**	**$1,660,325**

Producer (Agent) Appointments		
Type	**Number Issued**	***Fees Collected**
Original (Paper Appointments)	19,850	
Original (Electronic Appointments)	154,701	
Total	174,551	
Termination (Paper)	12,886	
Termination (Electronic)	74,466	
Total	**97,352**	
Appointments and Terminations		
Total	**261,903**	

*** Effective July 1, 2002, no fees are charged for appointments or terminations**

Producers (Agent/Broker) Examinations/Continuing Education		
	Number Administered	**Fees Collected**
Examinations	14,342	$358,550
	Number approved	**Fees Collected**
Continuing Education Courses	1,134	$56,700

Fiscal and Support Services

This Unit is responsible for accounting, budgeting, and procurement activities. Fiscal and Support Services is charged with ensuring compliance with State and Federal fiscal and procurement requirements. In addition, the Unit ovrsees the distribution of supplies and the Mailroom.

Personnel

This Unit is primarily responsible for human resources activities, including recruitment, hiring, payroll, and other personnel management functions. The Unit also ensures that the Maryland Insurance Admsinistration provides equal employment opportunitites and promotes affitmative action in all employment decisions.

Training and Facilities Management

This Unit is responsible for in-house training of personnel and facilities management and security.

MARYLAND INSURANCE ADMINISTRATION

CLASS TITLE	GRADE	STEP	SALARY
ASST ATTY GEN VI	22	13	78,128
MIA EXECUTIVE II	23	8	75,759
MIA OFFICER I	13	7	38,448
MIA OFFICER II	14	5	39,504
MIA ANALYST II	16	3	41,736
PRINCIPAL COUNSEL	25	13	95,401
MIA CHIEF ACTUARY	9990		112,106
MIA ADMINISTRATOR III	19	7	57,011
MIA ADMINISTRATOR V	21	7	65,072
ASST ATTY GEN VI	22	13	78,128
MIA ANALYST I	15	8	44,670
MIA ANALYST II	16	3	41,736
MIA ADMINISTRATOR IV	20	10	64,548
ASST ATTY GEN VI	22	11	75,148
ASST ATTY GEN VI	22	13	78,128
STATE INSURANCE COMM	9909		133,538
MIA ADMINISTRATOR II	18	8	54,412
MIA ADMINISTRATOR III	19	6	55,919
MIA ADMINISTRATOR II	18	2	45,805
MIA EXECUTIVE III	24	7	79,407
MIA OFFICER I	13	8	39,191
MIA ASSOCIATE VI	12	5	34,679
MIA ADMINISTRATOR I	17	4	46,287
MIA ADMINISTRATOR IV	20	6	59,738
ASST ATTY GEN IV	20	3	54,277
MIA ANALYST I	15	4	40,604
MIA ANALYST I	15	3	39,095
MIA EXECUTIVE III	24	7	79,407
MIA ADMINISTRATOR I	17	10	52,944
MIA ASSOCIATE V	11	8	34,406
MIA ADMINISTRATOR I	17	4	46,287
MIA ASSOCIATE V	11	3	30,153
MIA DEPUTY COMM	9907		110,100
MIA ANALYST II	16	9	48,627
MIA OFFICER I	13	3	34,322
MIA ANALYST I	15	13	49,176
MIA OFFICER I	13	10	40,718
ASST ATTY GEN V	21	7	65,072
MIA ADMINISTRATOR II	18	6	52,353
MIA ADMINISTRATOR I	17	4	46,287
MIA ADMINISTRATOR III	19	6	55,919
MIA ASSOC DEP COMM	9990		105,000
ACTUARY III L&H	16	11	50,535
MIA ADMINISTRATOR IV	20	10	64,548
MIA ADMINISTRATOR II	18	7	53,371
MIA ADMINISTRATOR I	17	3	44,559
MIA ADMINISTRATOR II	18	8	54,412
MIA ASSOCIATE V	11	3	30,153
MIA OFFICER II	14	5	39,504
MIA ASSOCIATE V	11	8	34,406
ASST ATTY GEN VIII	24	12	87,526
MIA ADMINISTRATOR I	17	5	48,084
MIA ADMINISTRATOR II	18	6	52,353
MIA ADMINISTRATOR II	18	7	53,371
MIA ANALYST II	16	4	43,351
MIA ANALYST II	16	4	43,351
MIA ASSOCIATE V	11	14	38,572
MIA ADMINISTRATOR IV	20	10	64,548
MIA ASSOCIATE III	9	3	26,512
MIA ASSOCIATE I	7	1	21,675
MIA OFFICER II	14	2	35,273
MIA OFFICER II	14	3	36,628
MIA ANALYST I	15	7	43,821
MIA ANALYST II	16	2	40,184
MIA OFFICER II	14	BASE	32,715
MIA ASSOCIATE V	11	2	29,047
MIA ANALYST I	15	11	47,319
MIA ADMINISTRATOR II	18	7	53,371
MIA ADMINISTRATOR II	18	3	47,583
MIA ANALYST I	15	7	43,821

	MIA ADMINISTRATOR II	18	7	53,371
	MIA ADMINISTRATOR II	18	4	49,432
	MIA ADMINISTRATOR IV	20	2	52,242
	MIA OFFICER I	13	14	43,960
	MIA ANALYST I	15	2	37,645
	MIA ANALYST II	16	3	41,736
	MIA ADMINISTRATOR V	21	5	62,598
	MIA ANALYST II	16	9	48,627
	MIA ASSOCIATE V	11	8	34,406
	MIA ANALYST I	15	6	42,989
	MIA EXECUTIVE II	23	11	80,312
	MIA ASSOCIATE IV	10	4	29,347
	MIA EXECUTIVE II	23	11	80,312
	MIA ADMINISTRATOR V	21	5	62,598
	MIA ANALYST I	15	3	39,095
	MIA OFFICER II	14	3	36,628
	MIA ADMINISTRATOR V	21	7	65,072
	MIA EXECUTIVE IV	25	14	97,280
	MIA ANALYST II	16	2	40,184
	MIA ADMINISTRATOR III	19	8	58,124
	MIA ANALYST I	15	2	37,645
	MIA ANALYST I	15	6	42,989
	INSURANCE EXAM V	15	10	46,419
	MIA ANALYST II	16	2	40,184
	MIA ANALYST II	16	3	41,736
	MIA OFFICER II	14	5	39,504
	MIA OFFICER II	14	3	36,628
	MIA ANALYST II	16	2	40,184
	MIA OFFICER II	14	2	35,273
	MIA EXECUTIVE IV	25	9	88,240
	MIA OFFICER II	14	5	39,504
	MIA OFFICER II	14	5	39,504
	MIA ANALYST I	15	2	37,645
	MIA ANALYST I	15	2	37,645
	MIA OFFICER II	14	2	35,273
	MIA ASSOCIATE IV	10	5	30,465
	MIA ASSOCIATE IV	10	3	28,271
	MIA ASSOCIATE VI	12	9	37,423
	MIA ADMINISTRATOR II	18	7	53,371
	MIA OFFICER II	14	5	39,504
	MIA OFFICER II	14	4	38,037
	MIA ASSOCIATE II	8	3	24,867
	MIA OFFICER I	13	10	40,718
	MIA ADMINISTRATOR II	18	16	63,514
	MIA ADMINISTRATOR IV	20	7	60,905
	MIA EXECUTIVE II	23	6	72,871
	MIA OFFICER II	14	3	36,628
	MIA ADMINISTRATOR I	17	6	49,017
	ADMIN AIDE GEN	11	10	35,740
	ACTUARY III L & H	16	11	50,535
	MIA ADMINISTRATOR IV	20	10	64,548
	MIA ADMINISTRATOR I	17	2	42,898
	MIA ADMINISTRATOR II	18	3	47,583
	MIA ANALYST I	15	4	40,604
	MIA ANALYST II	16	4	43,351
	OFFICE SERVICE CLERK	8	11	29,988
	ACTUARY III L & H	16	11	50,535
	MIA ANALYST I	15	2	37,645
	MIA ADMINISTRATOR IV	20	BASE	48,405
	MIA ADMINISTRATOR IV	20	6	59,738
	MIA ADMINISTRATOR I	17	4	46,287
	MIA ADMINISTRATOR I	17	11	53,975
	MIA ANALYST I	15	4	40,604
	MIA EXECUTIVE II	23	6	72,871
	MIA ADMINISTRATOR I	17	3	44,559
	MIA ADMINISTRATOR V	21	10	68,970
	MIA ANALYST II	16	4	43,351
	MIA OFFICER II	14	3	36,628
	MIA OFFICER II	14	BASE	32,715
	MIA ASSOCIATE III	9	3	26,512
	MIA ANALYST I	15	10	46,419
	MIA EXECUTIVE II	23	6	72,871
	MIA ADMINISTRATOR IV	20	9	63,309
	MIA ADMINISTRATOR II	18	14	61,103

	OFFICE SECY II GEN	9	11	31,992
	MIA ANALYST I	15	2	37,645
	MANAGEMENT ASSOC	13	6	37,721
	MIA ADMINISTRATOR I	17	2	42,898
	MIA EXECUTIVE IV	25	17	103,149
	MIA ADMINISTRATOR I	17	3	44,559
	MIA ADMINISTRATOR II	18	5	51,354
	MIA ADMINISTRATOR I	17	7	49,969
	MIA ADMINISTRATOR II	18	7	53,371
	SENIOR MC EXAMINER	14	11	44,314
	MIA OFFICER II	14	4	38,037
	MIA ANALYST I	15	1	36,250
	MIA OFFICER II	14	4	38,037
	MIA ANALYST I	15	4	40,604
	MIA ADMINSITRATOR IV	20	9	63,309
	OBS- MC EXAM P&C	13	11	41,504
	OFFICE SERVICE CLERK	8	11	29,988
	MIA ASSOCIATE IV	10	10	33,493
	MIA ASSOCIATE V	11	10	35,740
	MIA EXECUTIVE II	23	10	78,764
	MIA ASSOCIATE I	7	4	24,210
	MIA ASSOCIATE II	8	BASE	22,260
	MIA ADMINISTRATOR II	18	13	59,932
	PERSONNEL CLERK	9	11	31,992
	MIA ASSOCIATE III	9	2	25,545
	MIA ASSOCIATE IV	10	5	30,465
	MIA ADMINISTRATOR I	17	12	55,027
	MIA ASSOCIATE IV	10	5	30,465
	MIA ANALYST I	15	12	48,238
	MIA ASSOCIATE I	7	4	24,210
	MIA EXECUTIVE V	26	9	94,320
	MIA ASSOCIATE V	11	8	34,406
	MIA ASSOCIATE II	8	BASE	22,260
	MIA ASSOCIATE IV	10	5	30,465
	MIA ASSOCIATE V	11	7	33,759
	MIA ASSOCIATE III	9	1	24,616
	MIA OFFICER II	14	11	44,314
	MIA ADMINISTRATOR I	17	7	49,969
	MIA ASSOCIATE IV	10	1	26,243
	MIA ASSOCIATE IV	10	5	30,465
	MIA OFFICER I	13	13	43,125
	MIA ASSOCIATE IV	10	8	32,246
	MIA ANALYST I	15	16	52,100
	MIA OFFICER I	13	7	38,448
	MIA ADMINISTRATOR V	21	13	73,107
	MIA OFFICER I	13	6	37,721
	MIA ASSOCIATE V	11	7	33,759
	MIA EXECUTIVE I	22	8	70,893
	MIA ADMINISTRATOR I	17	4	46,287
	MIA ASSOCIATE V	11	14	38,572
	MIA ASSOCIATE III	9	2	25,545
	MIA OFFICER I	13	11	41,504
	MIA ASSOCIATE III	10	5	30,465
	MIA OFFICER I	13	7	38,448
	MIA ASSOCIATE III	9	1	24,616
	MIA ANALYST II	16	2	40,184
	ASST ATTY GEN VI	22	13	78,128
	MIA OFFICER I	13	9	39,947
	MIA ADMINISTRATOR III	19	9	59,259
	MIA OFFICER II	14	7	41,044
	ASST ATTY GEN VII	23	13	83,502
	MIA OFFICER II	14	8	41,839
	MIA OFFICER II	14	7	41,044
	MIA ASSOCAITE V	11	BASE	26,958
	MIA OFFICER II	14	7	41,044
	MIA OFFICER II	14	4	38,037
	MIA OFFICER II	14	2	35,273
	MIA OFFICER II	14	7	41,044
	MIA ANALYST I	15	8	44,670
	MIA ANALYST I	15	10	46,419
	MIA OFFICER II	14	8	41,839
	OFFICE SECY III GEN	10	10	33,493
	MIA EXECUTIVE IV	25	9	88,240
	MIA OFFICER I	13	5	37,009

	MIA ASSOCIATE IV	10	4	29,347
	ASST ATTY GEN VI	22	14	79,663
	MIA ADMINISTRATOR II	18	12	58,783
	MIA ASSOCIATE V	11	5	32,500
	MIA OFFICER II	14	7	41,044
	MIA ADMINISTRATOR IV	20	2	52,242
	MIA ANALYST II	16	BASE	37,255
	MIA ANALYST II	16	5	45,029
	MIA ASSOCIATE V	11	3	30,153
	ASST ATTY GEN VI	22	8	70,893
	MIA ANALYST I	15	9	45,535
	MIA ANALYST I	15	11	47,319
	TELEPHONE OPERATOR II	6	3	21,895
	MIA ASSOCIATE IV	10	7	31,640
	MIA ANALYST I	15	9	45,535
	MIA EXECUTIVE I	22	9	72,284
	MIA ANALYST I	15	9	45,535
	MIA ANALYST I	15	11	47,319
	MIA ASSOCIATE II	8	2	23,964
	MIA ANALYST I	15	5	42,174
	MIA ADMINISTRATOR II	18	2	45,805
	MIA ANALYST I	15	2	37,645
	MIA ASSOCIATE IV	10	1	26,243
	INSURANCE EXAM III	13	11	41,504
	MIA ADMINISTRATOR IV	20	12	67,100
	OFFICE SECY III GEN	10	10	33,493
	MIA OFFICER II	14	2	35,273
	MIA ADMINISTRATOR II	18	BASE	42,453
	MIA ADMINISTRATOR I	17	3	44,559
	OFFICE SECY III GEN	10	10	33,493
	MIA OFFICER II	14	2	35,273
	OFFICE SECY III GEN	10	11	34,135
	OFFICE SECY III GEN	10	11	34,135
	MIA ANALYST I	15	2	37,645
	MIA EXECUTIVE IV	25	11	91,749
	MIA ANALYST II	16	8	47,701
	MIA OFFICER II	14	2	35,273
	MIA OFFICER II	14	2	35,273
	MIA ANALYST I	15	2	37,645
	MIA ADMINISTRATOR II	18	2	45,805
	MIA ANALYST I	15	4	40,604
	MIA ANALYST I	15	BASE	34,908
	MIA ANALYST I	15	2	37,645
	MIA ADMINISTRATOR I	17	1	41,302
	MIA ADMINISTRATOR II	18	4	49,432
	MIA ANALYST I	15	2	37,645
	MIA ASSOCIATE I	7	2	22,487
	MIA ANALYST I	15	2	37,645
	MIA ANALYST I	15	11	47,319
	MIA ASSOCIATE IV	10	7	31,640
	MIA ANALYST I	15	2	37,645
	MIA ANALYST I	15	5	42,174
	MIA ANALYST I	15	2	37,645
	MIA ASSOCIATE IV	10	6	31,048
	MIA OFFICER II	14	2	35,273
	MIA OFFICER II	14	2	35,273
	OFFICE SECY II GEN	9	4	27,517
	MIA ADMINISTRATOR II	18	1	44,096
	MIA ANALYST I	15	5	42,174
	MIA ASSOCIATE III	9	10	31,391
	MIA ADMINISTRATOR II	18	2	45,805
	MIA OFFICER II	14	2	35,273
	MIA ANALYST I	15	2	37,645
	MIA OFFICER II	14	2	35,273
	MIA ANALYST I	15	5	42,174
	MIA ADMINISTRATOR IV	20	6	59,738
	MIA OFFICER II	14	6	40,267
	MIA ANALYST I	15	5	42,174
	MIA OFFICER II	14	2	35,273
	MIA ASSOCIATE II	8	3	24,867
	MHIP			

	MIA EXECUTIVE IV	25	13	95,401
	MIA EXECUTIVE II	23	8	75,759
	MIA ANALYST II	16	3	41,736
	MIA ASSOCIATE V	11	3	30,153
	MIA ADMINISTRATOR II	18	BASE	42,453
	MIA ANALYST I	15	BASE	34,908

VII. Examination and Auditing Section

The Examination and Auditing Section is responsible for the financial regulation of domestic and foreign insurance companies. This includes conducting financial analyses and examinations on licensed companies and applicants for licensing. The analyses and examinations are conducted for the primary purpose of detecting, as early as possible, licensed companies in financial trouble or those engaging in activities that are not in compliance with the laws and regulations of the State of Maryland.

This Section is the MIA's major revenue producer, having collected more than $193 million in premium and retaliatory taxes in FY 2002 and more than $228 million in FY 2003.

The Examination and Auditing Section consists of three major units:

- Company Licensing Unit
- Financial Examination Unit
- Auditing/Financial Analysis Unit

Company Licensing Unit

On an annual basis, the Company Licensing Unit renews insurers' certificates of authority and qualifies surplus lines insurers, accepted reinsurers, managing general agents, risk retention groups, motor clubs and fronting reinsurers. In addition, Company Licensing processes and makes recommendations to the Insurance Commissioner on the licensing of new domestic and foreign insurers, health maintenance organizations, dental plans, motor clubs and managed care organizations.

Company Licensing is responsible for maintaining a comprehensive database of insurers licensed to transact business in the State of Maryland. This database includes current addresses and historical information regarding name changes, mergers and redomestications. Most of this information became available on the Administration's website during this fiscal year.

The function of Service of Process, whereby the initial suit on a licensed insurer is accepted by the Administration and forwarded to the insurer, is now a part of this Section.

During FY 2002, Company Licensing reported to the Senate Finance Committee and the House Economic Matters Committee on the status of Workers' Compensation Self-Insurance Groups in Maryland.

As part of ongoing automation initiatives, Company Licensing implemented an on-line renewal process that allows companies to renew their Certificates of Authority via the MIA web site.

Financial Examination Unit

Section 2-205 of the Insurance Article, Annotated Code of Maryland, authorizes the Insurance Commissioner to conduct financial examinations of each licensed insurer as often as he deems advisable, but not less than every five years.

The Examination staff performs field examinations at the insurers' home and branch office in the State of Maryland or other states. The examinations may be routine scheduled reviews to assess the financial condition of insurers or limited or targeted to one or more areas of specific financial or regulatory concern. Upon the completion of each examination, a report on the examiners' findings is compiled. Expenses for these examinations are borne by the insurer examined.

During 2001, the Examination staff completed a total of 18 examinations, including one organizational examination. During the period January 1 to June 30, 2002, the Examination staff completed a total of 11 examinations, including seven limited scope examinations. During FY 2003, the Examination staff completed a total of 20 examinations, including one limited scope exam.

Financial Analysis Unit

The Financial Analysis staff is responsible for monitoring the financial solvency of the various insurers conducting business in the State of Maryland. The staff is primarily responsible for monitoring insurers domiciled in Maryland. This is accomplished by performing in-depth analyses of annual and quarterly financial statements filed by these insurers, and reviewing various other filings. In addition, the staff reviews financial information for insurers domiciled in other jurisdictions, as appropriate.

During calendar year 2001, the reviews resulted in 13 Orders for insurers domiciled in Maryland (six regarding acquisition of control, three involving releases of statutory deposits, one regarding a merger with an affiliated company, and three regarding exemptions from filing pre-acquisition of control notifications) and 10 Orders for insurers domiciled in other jurisdictions (one regarding a reorganization, two involving releases of statutory deposits, and seven regarding Certificate of Authority suspensions).

During the period January 1 to June 30, 2002, reviews resulted in four Orders for insurers domiciled in Maryland (one regarding the location of the home office, one regarding acquisition of control, one regarding a filing fine and one Consent Agreement whereby the authority to write a certain line of business was removed), and four orders for insurers domiciled in other jurisdictions (two regarding Certificate of Authority suspensions, one lifting a previous Certificate of Authority suspension, and one involving the release of a statutory deposit).

During FY 2003, reviews resulted in 11 Orders for insurers domiciled in Maryland (three regarding acquisition of control, one regarding a late filing penalty, three involving releases of statutory deposits, two regarding a merger with an affiliated company, one to make good an impairment or surplus, and one regarding the payment of fiduciary expenses) and 18 Orders for insurers domiciled in other jurisdictions (eight regarding Certificate of Authority suspensions, and 10 regarding release of statutory deposits).

The duties of the Audit/Analysis staff also include the auditing of the quarterly and annual premium tax reports upon their submission to the Insurance Administration. If discrepancies are found, insurers are subject to the assessment of additional taxes, penalties, and fees. In addition, the staff also reviews, for surplus line brokers, more than 800 semi-annual reports and approximately 45,000 monthly reports and affidavits. The Unit collected $4,232,493.40 in unauthorized business premium taxes in 2001 and $3,410,443.27 from January 1 to June 30, 2002, at a tax rate of three percent. The Section collected $7,972,669 in authorized business premium taxes in FY 2003, at a tax rate of three percent.

Summaries of all orders prior to January 1, 2002 are available on the MIA web site, www.mdinsurance.state.md.us. Orders issued after January 1, 2002 are available in full on the web site.

Statistical Data

2001 Company Licensing Activity	
Pending applications 1/1/01	21
Received in 2001	31
Total	**52**
Certificates of Authority issued	16
Applications withdrawn	12
Pending applications 12/31/01	24
Total Companies Licensed in Maryland As of December 31, 2001	**1,483**

Company Licensing Activity, January 1 to June 30, 2002	
Pending applications 1/1/02	24
Received in 2002	9
Total	**33**
Certificates of Authority issued	6
Applications withdrawn	3
Pending applications 12/31/01	24
Total Companies Licensed in Maryland as of June 30, 2002	**1,475**

Company Licensing Activity, FY 2003	
Pending applications 7/1/02	24
Received in 2003	23
Total	**47**
Certificates of Authority issued	24
Applications withdrawn	6
Pending applications 6/30/03	17
Total Companies Licensed in Maryland as of June 30, 2003	**1,462**

Companies Licensed 2001	
Company Name and State Domicile	Date Licensed
Aetna Dental Inc (TX)	3/22/01
American Skyline Insurance Company, Inc. (MD)	7/01/1
Berkley Insurance Company of the Carolinas (NC)	8/15/01
Cumberland Insurance Company, Inc. (NJ)	7/23/01
Funeral Directors Lie Insurance Company (CO)	8/15/01
Kemper Employers Insurance Company (IL)	4/11/01
Middlesex Mutual Assurance Company (CT)	7/1/01
MutualAid eXchang, Inc. (KS)	8/15/01
National Safety Life Insurance Company (PA)	1/12/01
Philanthropic Mutual Fire Insurance Company (PA)	1/12/1
Planet Indemnity Company (IL)	4/11/01
Safety First Insurance Company (IL)	10/9/01
Senior Citizens Mutual Insurance Company (FL)	12/8/01
Underwriter for the Professions Insurance Company (CO)	8/15/01
United National Specialty Insurance Company (WI)	8/15/01
Unitrin Direct Insurance Company (IL)	3/22/01

Companies Licensed-January 1 to June 30, 2002	
Company Name and State Domicile	Date Licensed
Alpha Dental Programs, Inc. (TX)	3/05/02
Great Western Insurance Company (UT)	4/10/02
Minnesota Lawyers Mutual Insurance Company (MN)	4/25/02
Omni Indemnity Company (IL)	6/07/02
Sentinel Insurance Company Ltd.	3/29/02
Sumitomo Marine and Fire Insurance Company of America	4/25/02

Companies Licensed – FY 2003	
Company Name and State Domicile	Date Licensed
Senior Life Insurance Company (GA)	7/8/02
Westcor Land Title Insurance Company (CA)	7/1/02
Commonwealth Insurance Company of America (WA)	8/23/02
Triumphe Casualty Company (TX)	9/24/02
State Mutual insurance Company (GA)	11/18/02
NIPPONKA Insurance Company of America (NY)	12/12/02
Republic Mortgage Insurance Company of Florida (FL)	12/12/02
Sterling Life Insurance Company (IL)	12/12/02
William Penn Life Insurance Company of New York (NY)	12/12/02/
Investors Heritage Life Insurance Company (KY)	12/27/02
Encompass Indemnity Company (FL)	1/30/03
Encompass Insurance Company of America (IL)	2/6/03
Fidelity National Title Insurance Company (CA)	2/24/03
The Hartford Steam Boiler Inspection & Insurance Company of Connecticut (CT)	2/24/03
21st Century Insurance Company (CA)	2/25/03
Equitable Life and Casualty Insurance Company (UT)	2/26/03
The Savings Bank Life Insurance Company of Massachusetts (MA)	2/26/03
Eagle Pacific Insurance Company	4/4/03
Fortress Insurance Company (IL)	4/4/03
GMAC Direct Insurance Company (MO)	4/4/03
Podiatry Insurance Company of America (RRG), A Mutual Company (IL)	4/4/03
Commerce Title Insurance Company (CA)	4/29/03

Esurance Insurance Company (OK)	5/5/03
GMAC Insurance Company Online, Inc. (MO)	5/6/03

Redomesticated Companies 2001	
Company Name and Change of Domicile	Effective Date
NGL American Life Insurance Company (From Wisconsin to North Dakota)	2/05/01
Progressive Home Insurance Company (From Tennessee to Ohio)	11/26/01
Redland Insurance Company (From Tennessee to Ohio)	12/31/01
Sentry Select Insurance Company (From Illinois to Wisconsin)	1/02/01
Specialty Surplus Insurance Company (From New Jersey to Illinois)	7/23/01
State National Specialty Insurance Company (From Florida to Texas)	10/25/01
Travelers Commercial Casualty Company (From Missouri to Connecticut)	10/01/01
United Life & Annuity Insurance Company (From Texas to Iowa)	12/31/01

Redomesticated Companies January 1 to June 30, 2002	
Company Name and Change of Domicile	Effective Date
Lyndon Life Insurance Company (From Missouri to Illinois)	3/29/02
Mapfre Reinsurance Corporation (From California to New Jersey)	4/12/02
Producers Agriculture Insurance Company (From Minnesota to Texas)	2/06/02

Redomesticated Companies – FY 2003	
Company Name and Change of Domicile	Effective Date
John Alden Life Insurance Company (From Minnesota to Wisconsin)	7/15/02
SAFECO Insurance Company of Indiana (From Pennsylvania to Illinois)	7/15/02
XL Specialty Insurance Company (From Illinois to Delaware)	8/16/02
QBE Insurance Corporation (From Delaware to Pennsylvania)	9/5/02
Reliance Life Insurance Company (From Arizona to Delaware)	9/23/02
Delta Dental Insurance Company (From Illinois to Delaware)	9/30/02
Provantis Insurance Company (From Arizona to Delaware)	9/30/02
Unimerica Insurance Company (From Maryland to Wisconsin)	10/16/02
Sterling Life Insurance Company (From Arizona to Illinois)	12/12/02
West Coast Life Insurance Company (From California to Nebraska)	12/20/02
Greenwich Insurance Company (From California to Delaware)	12/24/02
XL Insurance America, Inc. (From Wisconsin to Delaware)	12/24/02
Liberty Insurance Corporation (From Vermont to Illinois)	12/27/02
Allmerica Financial Life Insurance & Annuity Company (From Delaware to Massachusetts)	12/30/02
Northwestern National Casualty Company (From Wisconsin to Texas)	13/31/02
Peerless Indemnity Insurance Company (From New York to Illinois)	12/31/02
North Central Life Insurance Company (From Minnesota to Illinois)	1/16/03
Kansas City Fire and Marine Insurance Company (From Missouri to South Carolina)	1/21/03
AAA Life Insurance Company (From DC to Michigan)	2/7/03
American Travelers Assurance Company (From Iowa to DC)	3/7/03

Financial Examinations in progress as of January 1, 2001 and completed by December 31, 2001
1. CareFirst Inc.
2. CareFirst of Maryland, Inc.
3. Delmarva Health Care Plan, Inc.
4. Kaiser Foundation Health Plan Mid-Atlantic
5. First Care, Inc.
6. Free State Health Plan, Inc.
7. Montgomery Indemnity Insurance Company
8. Montgomery Mutual Insurance Company

Financial Examinations started and finished January 1, 2001 to December 31, 2001

1. Agency Insurance Company of Maryland
2. American Skyline Insurance Company **(Organizational Examination)**
3. Brethern Mutual Insurance Company
4. Fidelity and Guaranty Life Insurance Company
5. Graphic Arts Benefit Corporation
6. Injured Workers Insurance Fund
7. Monumental General Casualty Company
8. PHN-HMO, Inc.
9. Seaworthy Insurance Company
10. Verlan Fire Insurance Company

Examinations in progress on December 31, 2001
1. GeoVera Insurance Company**
2. Campmed Casualty & Indemnity Company of Maryland
3. Fidelity Insurance Company
4. Kaiser Foundation Health Plan Mid-Atlantic**
5. Medical Mutual Liability Insurance Society of Maryland
6. Professionals Advocate Insurance Company
7. USF&G Business Insurance Company**
8. USF&G Family Insurance Company**
9. USF&G Specialty Insurance Company**
11. United States Fidelity and Guaranty Company**
****Limited Scope Examination**

Examinations - 2002

Examinations in progress as of January 1 and completed by June 30, 2002
1. GeoVera Insurance Company**
2. Fidelity Insurance Company
3. Kaiser Foundation Health Plan Mid-Atlantic**
4. Medical Mutual Liability Insurance Society of Maryland
5. Professionals Advocate Insurance Company
6. USF&G Business Insurance Company**
7. USF&G Family Insurance Company**
8. USF&G Specialty Insurance Company**
9. United States Fidelity and Guaranty Company**
****Limited Scope Examination**

Examinations Started and Finished during the period of January 1 to June 30, 2002
1. Frederick Mutual Insurance Company
2. The Union Labor Life Insurance Company **(Limited Scope Examination)**

Examinations In Progress on June 30, 2002
1. Campmed Casualty & Indemnity Company of Maryland
2. Injured Workers Insurance Fund (**Limited Scope Examination)**
3. Interstate Auto Insurance Company, Inc.
4. Lexington National Insurance Company
5. MAMSI Life and Health Insurance Company
6. MD-Individual Practice Association, Inc.
7. Optimum Choice, Inc.
8. United Healthcare of the Mid-Atlantic, Inc.

Examinations In Progress as of July 1, 2002 and completed by June 30, 2003
1. Injured Workers' Insurance Fund **(Limited Scope Examination)**
2. Interstate Auto Insurance Company, Inc.
3. Lexington National Insurance Company
4. MAMSI Life and Health Insurance Company
5. MD-Individual Practice Association, Inc.
6. Optimum Choice, Inc.
7. United Healthcare of the Mid-Atlantic, Inc.

Examinations started and finished during FY2003
1. ACE Risk Assurance Company
2. ACE Guarantee Corp.
3. Amerigroup Maryland, Inc.
4. Colonial American Casualty and Surety Company
5. Dental Benefit Providers, Inc.
6. Fidelity Deposit Company of Maryland
7. Guardian Casualty Insurance Exchange
8. Helix Family Choice, Inc.
9. Maryland Casualty Company
10. Peninsula Indemnity Company
11. Peninsula Insurance Company
12. Priority Partner MCO, Inc.
13. Unimerica Insurance Company

Examinations in progress on June 30, 2003
1. Campmed Casualty & Indemnity Co. of Maryland
2. Farmers and Mechanics Mutual Insurance Association of Cecil County, Inc.
3. GeoVera Insurance Company
4. JAI Medical Systems MCO, Inc.
5. Maryland Care, Inc.
6. Union labor Life Insurance Company **(Limited Scope Examination)**
7. United States Fidelity and Guaranty Company
8. USF&G Specialty Insurance Company

Annual Statements Filed -2001	
Type of Insurer	**Number**
Life	552
Property and Casualty	870
Not for Profit	9
Title	24
Fraternal	29
Health Maintenance Organizations	15
Dental Plans	15
Managed Care Organizations	0
Risk Retention Groups	45
Surplus Lines	117
Accepted Unauthorized Reinsurers	64
Workers' Compensation Self Insurers	7
Motor Clubs	30
Total	**1,780**

Annual Statements Filed – through June 30, 2002	
Type of Insurer	**Number**
Life	554
Property and Casualty	920
Not for Profit	8
Title	25
Fraternal	27
Health Maintenance Organizations	14
Dental Plans	15
Managed Care Organizations	5
Risk Retention Groups	47
Surplus Lines	119
Accepted Unauthorized Reinsurers	69
Workers' Compensation Self Insurers	7
Motor Clubs	29
Total	**1,839**

Annual Statements Filed – FY 2003	
Type of Insurer	**Number**
Life	529
Property and Casualty	809
Not for Profit	8
Title	24
Fraternal	28
Health Maintenance Organizations	11
Dental Plans	13
Managed Care Organizations	5
Risk Retention Groups	45
Surplus Lines	103
Accepted Unauthorized Reinsurers	65
Workers' Compensation Self Insurers	6
Motor Clubs	27
Total	**1,673**

Other Documents Reviewed or Processed – 2001	
CPA Reports	1,780
Actuarial Reports	1,750
SVO Compliance Certificates	1,743
Management Discussion & Analysis	1,743
Holding Company Amendments	300
Premium Tax Quarterly Estimates	6,312
Premium Tax Year End	1,578
Premium Tax Audits	--0--
Surplus Lines Broker Semi-Annual Reports	734
Surplus Lines Monthly Reports	2,679
Surplus Lines Affidavits	32,993
Certificates of Filed Documents	2,689

Other Documents Reviewed or Processed – 2002	
CPA Reports	1,839
Actuarial Reports	1,805
SVO Compliance Certificates	1,798
Management Discussion & Analysis	1,798
Holding Company Amendments	100
Premium Tax Quarterly Estimates	3,180
Premium Tax Year End	1,590

Premium Tax Audits	1,666
Surplus Lines Broker Semi-Annual Reports	348
Surplus Lines Monthly Reports	2,749
Surplus Lines Affidavits	16,993
Certificates of Filed Documents	1,685

Other Documents Reviewed or Processed – FY 2003	
CPA Reports	1,427
Actuarial Reports	1,427
SVO Compliance Certificates	1,427
Management Discussion & Analysis	1,427
Corporate Amendments	100
Premium Tax Quarterly Estimates	5,856
Premium Tax Year End	1,464
Premium Tax Audits	1,620
Surplus Lines Broker Semi-Annual Reports	899
Surplus Lines Affidavits	44,652
Certificates of Filed Documents	1,523

Late Forfeiture Fees Assessed - 2001	
COMPANY NAME	**AMOUNT PAID**
Alta Health & Life Insurance Company	$12,000
Ari Mutual Insurance Company	7,000
Associates Financial Life Insurance Company	2,500
AXA Corporate Solutions Life Reinsurance Company	13,000
Campmed Casualty & Indemnity Company of Maryland	6,000
Chicago Insurance Company	316,000
Civil Service Employees Insurance Company	5,000
Columbus Life Insurance Company	7,000
Continental National Indemnity	11,000
Equitable of Colorado, Inc.	11,000
Financial Security Assurance Inc.	12,000
Firemen's Insurance Company of Washington, DC	8,000
First American Property & Casualty Insurance Co.	5,000
General Security Insurance Company	18,000
Gramercy Insurance Company	12,000
Guideone Mutual Insurance Company	11,000
Guideone Specialty Mutual Insurance Company	11,000
Highmark Life Insurance Company	14,000

Investors Guaranty Life Insurance Company	22,000
The American Road Service Insurance Company	19,000
United Investors Life Insurance Company	1,500
TOTAL	**$524,000**

Late Forfeiture Fees Assessed
January 1 to June 30, 2002

COMPANY NAME	PENALTY AMOUNT	PAID
AIG Annuity Insurance Company	$4,500	$4,500
American Fuji Fire & Marine Insurance Company	7,000	7,000
American Travelers Assurance Company	7,000	7,000
Argonaut Great Central Insurance Company	4,500	4,000
Colonial Surety Company	4,000	4,000
TOTAL	**$27,000**	**$26,500**

Premium and Retaliatory Taxes Collected – 2001

Type of Insurer	Premium	Retaliatory
Property & Casualty	$ 107,266,336	$ 850,000
Life	59,193,393	350,000
Dental Plans	862,938	--0--
Title	1,635,409	--0--
Unauthorized Insurers	606,971	--0--
Surplus Lines	3,984,909	--0--
Totals	**$ 173,549,956**	**$ 1,200,000**

Premium and Retaliatory Taxes Collected – 2002

Type of Insurer	Premium	Retaliatory
Property & Casualty	$ 45,153,642	$ 850,000
Life	26,080,336	350,000
Dental Plans	767,402	-0-
Title	1,444,080	4,207
Unauthorized Insurers	119,904	-0-
Surplus Lines	2,412,026	-0-
Totals	**$ 75,977,390**	**$ 1,204,207**

Because premium and retaliatory taxes are collected on a calendar year basis, there will not be amounts collected for 2003 until later in 2004.

VIII. Life and Health Section

The Life and Health Section is composed of the Rates and Forms Review Unit, the Medical Director/Private Review Agent Oversight Unit, and until July 2002, also included the Life and Health Market Conduct and Agent Enforcement Units. Beginning in FY 2003, these units joined with the Property and Casualty Market Conduct and Agent Enforcement Units to become the Compliance and Enforcement Section.

The Life and Health Section oversees the contracts written by insurers, health maintenance organizations (HMOs), nonprofit health service plans, and dental plan organizations. The types of contracts reviewed by the Life and Health Section include life insurance, annuities, credit insurance, health insurance, dental insurance, long-term care insurance, and Medicare supplement insurance.

This Section works closely with the Consumer Complaint Investigation Section in handling consumer complaints that call for technical expertise. The review of legislative proposals and the development of regulations are an essential part of the Life and Health Section's responsibility.

Rate and Form Review Unit

Every life insurance policy, health insurance policy, dental plan organization contract, annuity contract, credit insurance policy, and health maintenance organization contract used in the State of Maryland must be submitted to the Insurance Commissioner for prior approval. It is the responsibility of the Rate and Form Review Unit to review these filings to determine compliance with Maryland law, regulations and rules. In addition, this Unit reviews ancillary filings such as provider contracts, advertising marketing materials, and internal grievance procedures.

A major responsibility of this Unit is the review of initial health insurance rate filings to ensure that the rates are not excessive, inadequate, or unfairly discriminatory. This Unit is also responsible for reviewing the rates and annual filings required of all insurers in the Medicare supplement market to determine compliance with mandated minimum loss ratio requirements. Life insurance and annuity actuarial memoranda are reviewed to determine that nonforfeiture benefits are in compliance with the statutes. Credit life and disability insurance rate filings are reviewed to ensure compliance with the applicable regulations. Insurers issuing credit life, credit disability and credit involuntary unemployment insurance must file detailed annual reports regarding their operations. These reports are reviewed to determine whether the rate standards are being adhered to and whether revisions may be in order. Insurers issuing Medicare Supplement policies and Specified Disease policies are also required to file annual reports that demonstrate compliance with loss ratio requirements.

The granting of special permits to qualifying organizations for the purpose of authorizing Charitable Gift Annuities is another function of this Unit. In addition, applications for variable product authority are reviewed and recommendations are made regarding an insurer's ability to write these lines of business.

This Unit also works closely with the Market Conduct Unit, in providing technical expertise for examination of life and health carriers, as well as assisting in the performance of Market Conduct desk audits.

Life & Health Statistical Data		
	FY 2002	FY2003
Forms Received:	12,285	14,632
Life	4,110	4,340
Health	5,529	7,069
Annuity	2,168	2,828
Credit	478	395
Reports Received	410	441
Rate Filings	1,565	1,837
Actuarial Memos Reviewed	1,105	1,319
Rate Deviations	224	212
Advertising	1,411	1,144
Inquiries From The Public (Telephone)	1,418	1,557
Calls From Insurance Companies	7,336	7,547
Internal Grievance Documents Filed	13	7
Medical Director/PRA Applications Received	352	184
Medical Director/PRA Applicants Certified	134	25

Medical Director/Private Review Agent Oversight Unit

The Medical Director/Private Review Agent Oversight Unit is responsible for reviewing the qualifications of applicants seeking certification as a Medical Director of a Health Maintenance Organization or Private Review Agent.

Any physician employed or under contract with a health maintenance organization who establishes policies and procedures for quality assurance and utilization management, compliance with quality assurance and utilization management policies and procedures, and oversight of Utilization Review decisions of Private Review Agents employed or under contract with the Health Maintenance Organization must be certified by the Commissioner. The Unit ensures that physicians designated as Medical Directors meet the statutory and regulatory requirements for certification by the Commissioner.

The Unit is also responsible for reviewing applications for Private Review Agent certification. Any person or entity conducting Utilization Review that is either affiliated with, under contract with or acting on behalf of a Maryland business entity or a third party that pays for, provides or administers health care services to citizens of this State must receive a Certificate of Registration from the Commissioner. Utilization Review is

the system for reviewing the appropriate and efficient allocation of health services given or proposed to be given to a patient or group of patients.

The Unit works closely with the Compliance and Enforcement Section and Appeal and Grievance Unit to provide technical expertise regarding violations of the Insurance Article or the Code of Maryland Regulations.

Market Conduct Unit

The Life and Health Market Conduct Unit was formed to complement financial examinations by examining the non-financial activities of Life and Health insurance companies.

Market conduct examiners review company operations to determine how the company operates in the market place. The examiners' review includes but is not limited to sales practices, advertising materials, underwriting practices and claims handling practices. Examinations often help alert companies to problems and serve as a form of consumer protection. The examination report presents a detailed analysis of a company's general business practice.

In 1999, the Unit began to focus on conducting Target Examinations. These examinations are targeted to a specific statute, regulation or business practice. Some examples of targeted examinations include compliance with Maryland's Prompt Pay statute and Small Group Reform.

The Unit's responsibilities include the examination of all Life and Health insurers, including health maintenance organizations, dental plans, vision plans, not-for-profit organizations and private review agents. The Unit works closely with the Life & Health Agent Investigation Unit in examining agent records as part of the market conduct examination process.

The cost of market conduct examinations is borne by the insurers. In FY 2002, the total amount billed to Life and Health companies was $836,410. In FY 2002, there were 16 completed Market Conduct Examinations and reports filed and 22 company examinations were in progress as of June 30, 2002.

As of July, 2002, the Life and Health and Property and Casualty Market Conduct and Agent Enforcement units merged to form the Compliance and Enforcement Section.

FY 2002 Life and Health Market Conduct Consent Orders

(bold, italicized orders have a stay of penalty)

COMPANY NAME	PENALTY AMOUNT	EFFECTIVE DATE
United Healthcare of Mid-Atlantic	$300,000.00	07/16/01
Group Insurance Administration, Inc.	$500.00	07/23/01
CareFirst of Maryland, Inc. (Order/GetIntegrated)	no fine	08/07/01

Magellan Behavioral Health, Inc.	***$150,000.00***	***08/14/01***
Golden Rule Ins. Co.	$2,500.00	08/20/01
Aetna Life Ins. Co., Inc. (Order/Administaff)	no fine	08/23/01
Aetna U.S. Healthcare, Inc. (Order/Administaff)	no fine	08/23/01
Aetna U.S. Healthcare, Inc. (APTNet)	$600,000.00	09/05/01
Optimum Choice, Inc. (Shore Health Lab.)	$5,000.00	10/02/01
Kaiser Foundation Health Plan	$50,000.00	10/04/01
George Washington University	***no fine***	***10/29/01***
United Concordia Dental Plans, Inc.	$50,000.00	10/31/01
All American Life Insurance Company	$75,000.00	11/28/01
American Bankers Ins. Group, Inc.	***$3,000,000.00***	***12/19/01***
Connecticut General Life	$40,000.00	12/19/01
American-Amicable Life Ins. Co. of TX	***$100,000.00***	***01/07/02***
Union Security Life Ins. Co.	$300,000.00	01/30/02
Chesapeake Life Insurance Company	$25,000.00	02/08/02
United Healthcare of Mid-Atlantic	$2,500.00	02/20/02
Bankers Life & Casualty Co.	$2,500.00	03/01/02
Monumental Life Ins. Co.	$7,000.00	04/01/02
Fort Dearborn Life Ins. Co.	$1,000.00	04/02/02
Fidelity Insurance Company	***$70,000.00***	***05/01/02***
American Psych Systems, Inc.	$30,000.00	05/02/02
Liberty Life Insurance Company	$60,000.00	06/03/02
MAMSI Life and Health Ins. Co.	$20,000.00	06/21/02
Connecticut General life	$50,000.00	06/26/02
TOTAL	**$4,941,000.00**	

Agent Investigation Unit

The Life and Health Agent Enforcement Unit conducts investigations of agents and unauthorized entities. Market Conduct examinations are frequently initiated based upon violations discovered during agent investigations. Conversely, investigations of agents have proceeded based upon the findings of Market Conduct examinations. The Unit operates in conjunction with Market Conduct to monitor the conduct of insurance agents. This is done through the review of agent files, applications and consumer complaints at the home office of the carrier. Working jointly provides a proactive approach and offsets some of the expense of investigations since it is considered part of the market conduct exam.

Included among the unit's accomplishments in FY2002 are the following:

- Completing the agent portion of eight Market Conduct exams and pursuing administrative actions against the agents.
- Conducting an investigation involving a carrier who overcharged for credit insurance to Maryland purchasers of new cars in 1994 and 1995. Restitution of $195,000 was made to 200 consumers.
- Numerous refunds were made to Maryland citizens including individual amounts of $330,000 and $450,000 as a result of investigations which indicated unsuitable sales to older citizens and unapproved products. The total amount of restitution gained for

Maryland citizens during the year was $1.4 million. There were 26 orders and consent orders taking administrative actions against agents.

As of July, 2002, the Life and Health and Property and Casualty Market Conduct and Agent Enforcement units merged to form the Compliance and Enforcement Section.

Agent Investigation Statistical Data – Fiscal Year 2002

Investigations assigned	280
Investigations closed	250
Life cases	141
Health cases	51
Unauthorized insurers and others	51
Investigations open	83
Consent Orders	14
Cases forwarded for Administrative Hearing	31
Cases pending Review of Legal Sufficiency	14
Orders Issued	26
Revocations	12
Suspensions and Fines	3

IX. Property and Casualty Section

The Property and Casualty Section is composed of the Rates and Forms Review Unit and until July, 2002, also included the Property and Casualty Market Conduct and Agent Enforcement Units. Beginning in FY 2003, these units joined with the Life and Health Market Conduct and Agent Enforcement Units to become the Compliance and Enforcement Section.

The Property and Casualty Section oversees the regulation of all insurance companies that sell property, casualty, surety, mortgage guaranty, or title insurance in Maryland.

Rate and Form Review Unit

All insurance companies that operate under a Certificate of Authority to provide property, casualty, surety, mortgage guaranty, or title insurance, are required to file with the Commissioner all policy forms, endorsements, rates, rating plans, rating rules and amendments to these items. The Rate and Form Review Unit reviews these filings to determine compliance with the Insurance Article and regulations. All policy forms require the Commissioner's prior approval before they can be used. Rates require prior approval in some lines, but not in others.

The Insurance Reform Act of 1995 (Competitive Rating) authorized insurers to use rates for certain lines of insurance, presumed to be within a competitive market, without prior approval of the Commissioner. The goal of this Act is to permit insurers in these lines to provide rates that are responsive to competitive market conditions and to improve the availability of insurance in the State. Lines excluded from the Act, i.e., lines that need prior approval by the Commissioner are surety, title, medical malpractice, and insurance provided by the Maryland Automobile Insurance Fund. Because no approval is granted for rates in competitive lines, the insurer may use the rate as soon as it is filed with the MIA. This Unit is responsible for reviewing each filing in order to ensure the filings are in compliance with the Insurance Article and regulations. These filings may be subject to a hearing if compliance is questioned.

The actuarial staff in the Rate and Form Review Unit reviews filings to ensure that all rates, rating plans, and rating rules, in all lines, are not excessive, inadequate or unfairly discriminatory. In addition, the Rate and Form Review Unit assists the Consumer Complaint Investigation Section in handling consumer complaints that involve rate changes or coverage questions.

Revenue from Rate and Form Filings

Legislation that established the MIA as an independent agency also established fees for the filing of rates and forms. The revenue produced from the collection of these fees totaled $1,499,900 for FY 2002 and $1,568,230 for FY 2003. Photocopying fees

from requests for copies of rate and form filings and other miscellaneous fees generated $3,628.70 in FY 2002 and $9,620 in FY 2003.

Premium Finance Companies

A premium finance company must register with the Commissioner before engaging in the business of financing premiums in the State. The Rate and Form Unit reviews these registration materials and all contracts used by the company. Premium Finance Companies must renew registrations for licensing every July 1. During FY 2002, 96 premium finance registrations were received and $4,800 was collected in fees. During FY 2003, 91 premium finance registrations were received and $4,550 was collected in fees.

Motor Clubs

Although motor clubs do not engage in insurance business, they are not exempted from the laws relating to insurance or insurance services. The Commissioner regulates the registration of these entities. This Unit reviews all motor club contracts and rates used by the clubs and coordinates with Examination and Auditing to assess the requirements for licensing by the Commissioner. In FY 2002 there were 34 motor clubs operating in Maryland and in FY 2003 there were 29.

Consumer Information

The Rate and Form Review Unit provides data for the various rate guides the Maryland Insurance Administration provides to consumers. These guides provide valuable information for consumers on such topics as Homeowners Insurance, Personal Automobile Insurance and Workers' Compensation Insurance.

Risk Purchasing Groups

To promote the formation and multistate operation of group liability insurance programs, Congress enacted the Risk Retention Act in 1981 and expanded its scope in 1986. By preempting prohibitive state laws, it was the congressional intent to enable businesses, nonprofit organizations, professionals, and governmental agencies to establish self-insurance pools in the form of Risk Retention Groups and to purchase liability insurance on a group basis through purchasing groups. The Examination and Auditing Section registers and licenses the Risk Retention Groups. The Rate and Form Review Unit is responsible for the registration of Purchasing Groups as well as reviewing the rates and forms used by the licensed insurers that provide insurance to the Purchasing Groups. There were six new Purchasing Groups registered in FY 2002 for a total of 393 Purchasing Groups doing business in Maryland. Registration fees totaling $600 were also collected. In FY 2003, there were five new Purchasing Groups registered bringing the total to 300 groups doing business in the State. Registration fees totaling $500 were also collected.

Workers Compensation Insurance

In an effort to stay current on workers' compensation issues important to the insurance industry, the business community and consumers, the Property and Casualty staff members attend committee meetings of the Workers' Compensation Benefit and

Insurance Oversight Committee of the Maryland General Assembly. Each November, the Associate Commissioner of Property and Casualty goes before the Oversight Committee and reviews the condition of workers' compensation insurance in the State, and provides information about the effects of competitive rating on this line of insurance.

As of July, 2002, the Life and Health and Property and Casualty Market Conduct and Agent Enforcement units merged to form the Compliance and Enforcement Section.

Market Conduct Unit

The Property and Casualty Market Conduct Unit performs personal and commercial lines market conduct examinations of insurance companies and premium finance companies pursuant to Section 2-205 of the Insurance Article.

Insurers

Market Conduct examinations of insurers involve detailed on-site examinations of the underwriting, sales and advertising and claims handling activity of domestic and foreign insurers both within and outside the State of Maryland. A Market Conduct Report is issued after each examination.

In FY 2002, the Market Conduct Unit completed examinations of 28 insurers. As of June 30, 2002, 36 examinations were in progress. The cost of the Market Conduct Examination is borne by the insurer. The cumulative examination expenses received from companies in FY 2002 was $866,424.63.

As a result of the examinations, administrative penalties in the amount of $676,472.00 were assessed against companies and $593,554 was returned to insureds/claimants.

Examinations - Insurance Companies – FY 2002

Examinations Completed	28
Examinations in Progress	36
Examination Expenses Received	$866,424.63
Administrative Penalties Assessed	$676,472.00
Money Returned to Maryland Residents	$593,554.00

Premium Finance

The Market Conduct Unit also examines premium finance companies. The examinations involve detailed on-site review of premium finance companies' compliance with Title 23 of the Insurance Article. This includes the proper execution of contracts, return of money due to the borrower, computation of accurate finance charges,

registration with the Insurance Administration, and determination of whether citizens are being burdened with duplicate coverage by insurance agents.

As of June 30, 2002, the Market Conduct Unit had no open examinations of premium finance companies.

As of July, 2002, the Life and Health and Property and Casualty Market Conduct and Agent Enforcement units merged to form the Compliance and Enforcement Section.

Agency Enforcement Unit

The Property & Casualty Agent Enforcement Unit conducts investigations of individuals and business organizations that hold certificates of qualification as insurance producers, title insurance agents or bail bondsmen. The following is a summary of the investigations initiated and actions taken during fiscal year 2002.

Investigations Completed	15
Investigations in Progress	91
Administrative Penalties Ordered	$102,250.00
Restitution Ordered	$26,421.32
Number of License Revocations	11
Number of License Suspensions	0

Investigations

An Agent Enforcement investigation is generated by referrals from consumers, insurers, Motor Vehicle Administration, States' Attorneys and both federal and state law enforcement agencies. Investigations involve on site visits to the producer's office where files, bank records and appointment logs are reviewed. An Enforcement Officer prepares the case for administrative hearing and acts as the State's witness at the hearing.

As of July, 2002, the Life and Health and Property and Casualty Market Conduct and Agent Enforcement units merged to form the Compliance and Enforcement Section.

X. Consumer Complaint Investigation Section

The Consumer Complaint Section investigates property, casualty, life, and health complaints made by policyholders, claimants, beneficiaries, and providers of health care services. The Section is divided into three units. The Appeals & Grievance Unit investigates whether a particular healthcare service is medically necessary. The Life & Health Unit resolves complaints involving claims payment and determinations as to whether a particular service is covered under the terms of the insured's contract. The Property & Casualty Unit investigates automobile, homeowner and other complaints regarding property and casualty insurance policies. In addition to taking action on individual complaints, business practices discovered during the complaint process may lead to market conduct examinations. In FY 2002, the Section handled approximately 24,035 complaints and in FY 2003, the Section handled 27,079 complaints.

The Complaint Section sends surveys to all consumers who filed complaints and sends closing letters to complainants where the Administration has jurisdiction over the complaint. The survey asks how the consumers learned of the Administration and whether they were satisfied with the complaint process.

From July, 2001 through June 30, 2002, 16,406 surveys were mailed to complainants. The Administration received 2,805 responses. In FY 2003, 10,814 surveys were mailed and 1,640 responses were received. Consumers indicated that they have learned about the Administration in a variety of ways but most frequently either through their health care provider, their insurance agent, or insurance carrier. The majority of the consumers were either satisfied or very satisfied with the process. This holds true even for those consumers who did not have the case decided in their favor. Also, overwhelmingly consumers have indicated that they would use the process again.

Appeals & Grievance Unit

The Appeals and Grievance Law passed by the General Assembly in 1998 established a procedure for consumers to appeal decisions made by health maintenance organizations (HMO's), insurers and nonprofit health service plans (also referred to as "Carriers" or "health plans") that a covered health service is not "medically necessary." The law took effect January 1, 1999, and was codified at §15-10A et seq. of the Insurance Article. One key component of the legislation is a consumer's right to internal and external review where care is denied on the grounds that it is not "medically necessary."

In most cases, a consumer must exhaust the internal grievance procedure of their health insurer before the Administration can conduct an independent review of the denial. The Appeals & Grievance Law creates specific standards and time frames to which health insurers must adhere in operating their internal grievance processes. In addition, the Appeals & Grievance Law provides the Insurance Administration with tools such as the ability to enter into contracts with independent review organizations (IROs) to enable it to independently review denials by health insurers that are based on an alleged lack of medical necessity.

A comprehensive report is prepared in accordance with §15-10A-06 of the Insurance Article for the calendar year. This report provides a detailed analysis of the complaints handled by the Administration as well as the data reported by the carriers concerning the cases.

In FY2002, the Appeals & Grievance Unit received 1,227 complaints and in FY 2003 the Appeals & Grievance Unit received 1,305 complaints.

The statutory authority for the Commissioner to enforce the Appeals & Grievance law is found in § 15-10A et al, §15-10B et al, §4-113, and §27-303. These provisions allow the Commissioner to require the payment of medically necessary services. In addition, the Commissioner may fine Carriers for 1) failure to authorize medically necessary treatment; 2) sending an adverse or grievance decision letter which did not comply with the law; 3) failure to timely authorize medically necessary services; and 4) failure to have the appropriate physician conduct the utilization review.

During FY 2002, the Administration issued 45 Orders and entered four Consent Orders based on the complaints it received. Administrative penalties of $59,250.00 were imposed as a result of these Orders. In FY 2003, the Administration issued 60 Orders and eight Consent Orders with a total of $197,750 in administrative penalties imposed. The Orders issued have required coverage of various services including residential treatment for minors; durable medical equipment; coverage of inpatient hospital days; coverage of emergency room visits; bilateral breast reduction; finding that treatment was not experimental; coverage of various prescriptions; coverage of dental procedures.

Life & Health Unit

The Life & Health Unit investigates complaints regarding premium problems, claims handling, coordination of benefits, and agent misrepresentations against health maintenance organizations, long-term care, dental care, and commercial life and health insurance companies.

During FY 2002, the Unit received 6,870 complaints from citizens and providers of medical care. The majority of the complaints involved delay or denial of payment of claims. The Administration does not have jurisdiction to investigate self-funded employee benefit plans, Medicaid, Medicare, and Federal Employee Health Benefit plans. When complaints are received involving these issues, the complaint is referred to the proper agency. Through the successful conclusion of the complaints over which the Administration has jurisdiction, $2,512,865 was recovered for Maryland citizens in the form of claims payment or restitution. Also, 88 hearings were requested during FY 2002 and 27 Orders were issued against companies. The majority of these Orders were for violation of the prompt pay law (§ 15-1005 of the Insurance Article) and retroactive reimbursement law of §15-1008 of the Insurance Article.) Administrative penalties of $30,400 were imposed.

During FY 2003, the Unit received 5,361 complaints, 66 hearings were requested, 47 Orders were issued, one Consent Order was finalized, $15,500 in administrative penalties was imposed, and $1,352,942 was recovered for the citizens of Maryland.

Property & Casualty Unit

Complainants request assistance from the Property & Casualty Unit when their property and casualty policies are canceled or non-renewed, when their premiums are increased, or when their coverage is modified by the insurers in some manner. Most complainants request assistance during the claim settlement process, frequently inquiring whether there is coverage for the claim, or if the insurer has paid or denied the claim in an appropriate manner. The services provided by the Property & Casualty Unit often result in the continuation of coverage, the return of premiums to insureds, or the settlement of claims.

In FY 2002, the Unit received 5,382 complaints that involved issues other than personal automobile liability cancellations, non-renewals, reductions in coverage and increases in premiums. As a result of processing the justified complaints, a total of $1,096,090 was recovered for Maryland residents from insurance companies, agents, and brokers. In FY 2003, 6,192 complaints were received and $1,248,169 was recovered for citizens.

Section 27-605 of the Insurance Article gives the citizens of the State of Maryland the right to protest the cancellation or non-renewal of an automobile insurance policy; a reduction in coverage under an automobile insurance policy; or an increase in a premium due to a surcharge under an automobile policy. In Fiscal Year 2002, the Property & Casualty Unit received 10,227 protests in accordance with §27-605 of the Insurance Article. The number of protests in FY 2003 was 13,972.

In those instances where an investigation results in the need for a hearing, the Unit prepares the case for the hearing. In FY 2002, the Unit prepared 355 cases for hearings as a result of personal automobile policy termination, while 238 hearing requests involved complaints other than personal automobile terminations. In FY 2003, 364 hearings were prepared for personal automobile policy termination cases and 188 hearings were prepared in other cases.

In certain instances, the investigations indicate that further administrative action is warranted. The Property & Casualty Unit finalized 44 Orders and 2 Consent Orders which required administrative penalties to be paid, claims to be settled and policies to be reinstated. A total of $23,000 in administrative penalties was imposed. The primary reason for these Orders was the companies' failure to provide information to the Administration. In FY 2003, 36 Orders and four Consent Orders were finalized with $24,500 in administrative penalties.

To protect the confidentiality of the complainant, Orders and Consent Orders from this Section are not posted on the MIA web site. Redacted copies are available by calling the Maryland Insurance Administration, 1-800-492-6116.

Appeal and Grievance Statistics
Totals for Complaints Filed
July 1, 2001 - June 30, 2002

COMPLAINTS FILED		**1227**
NO JURISDICTION		**409**
Referred to DOL (*ERISA)*	**217**	
Referred to OPM *(FEHBP)*	**57**	
Referred to Medicaid	**22**	
Referred to Medicare	**10**	
Referred to Insurance Department in Another State	**78**	
Referred to Other*	**25**	

*Includes complaints referred to Workers Compensation Commission and Other State agencies

COMPLAINT WITHDRAWN		**20**
INSUFFICIENT INFORMATION		**86**
NO ADVERSE DECISION/OTHER		**142**
Referred to HEAU to Exhaust Internal Remedy	**285**	
MIA Conducted Investigation:	**279**	
Carrier Reversed Itself During Investigation	**87**	
Carrier Upheld by MIA	**143**	
Carrier Reversed by MIA	**39**	
Carrier Modified by MIA	**10**	

Appeal and Grievance Statistics
Totals for Complaints Filed
July 1, 2002 - June 30, 2003

COMPLAINTS FILED		**1305**
NO JURISDICTION		**339**
Referred to DOL (ERISA)	**194**	
Referred to OPM (FEHBP)	**45**	
Referred to Medicaid	**16**	
Referred to Medicare	**9**	
Referred to Insurance Department in Another State	**67**	
Referred to Other*	**9**	

*Includes complaints referred to Workers Compensation Commission and Other State agencies

COMPLAINT WITHDRAWN		**6**
INSUFFICIENT INFORMATION		**101**
NO ADVERSE DECISION/OTHER		**292**
Referred to HEAU to Exhaust Internal Remedy	**312**	
MIA Conducted Investigation:	**255**	
Carrier Reversed Itself During Investigation	**74**	
Carrier Upheld by MIA	**137**	
Carrier Reversed by MIA	**55**	
Carrier Modified by MIA	**14**	

XI. Compliance & Enforcement Section

In August 2002, the Market Conduct and Agent Enforcement Units for Life & Health and Property & Casualty combined under the newly formed Compliance & Enforcement Section. Most states in the country currently combine the Market Conduct and Agent Enforcement Section into one unit. Combining the units allows for an increase in productivity and efficiency through the consolidation of management and sharing of support staff. Additionally, combining the units has allowed for uniformity and the implementation of best practices in investigative technique, report drafting and penalty calculations.

The Section provides regulatory oversight of the insurance industry through examinations and investigations. Certain market conduct examinations are comprehensive in nature and required periodically by law. Other examinations result from the MIA's mission to protect consumers from deceptive marketing practices, unfair claim settlement practices, underwriting and premium rating abuses and misrepresentation of coverage. These "target" examinations are often in response to consumer complaints or new laws and regulations.

The Section is divided into three units: the Life & Health Market Conduct Unit, the Property & Casualty Market Conduct Unit, and the Producer (Agent) Enforcement Unit.

The Life & Health Market Conduct Unit performs examinations of Life and Health carriers, health maintenance organizations (HMOs), not-for profit organizations, credit insurance companies, dental plans, vision plans, pharmacy benefit plans, Private Review Agents, and behavioral health plans. Current issues facing the Life & Health Market Conduct Unit include race-based discrimination in life insurance rates, prompt payment and appropriate adjudication of insurance claims, proper handling of claim denials, and inclusion of mandated benefits in health insurance plans.

The Property & Casualty Market Conduct Unit performs examinations of personal and commercial lines, including private passenger auto, homeowners, motor clubs, premium finance companies, title insurers, commercial liability and commercial property coverage. Current issues facing the Property & Casualty Market Conduct Unit include terrorism and mold exclusions, consumer access and availability to homeowner insurance, enforcement of new prohibitions and limitations on the use of credit history and scores in homeowner and personal passenger auto and inappropriate premiums and termination of commercial risks.

The Producer (Agent) Enforcement Unit works closely with the Market Conduct Units and investigates complaints regarding individual producers for property, casualty, life and health insurance, bail bondsmen, public adjusters, and title agents. Current issues facing the Producer Enforcement Unit include suitability of insurance sales, real estate "flipping" transactions, and bail bondsmen.

The NAIC is working to develop a uniform market conduct process and encourages collaborative efforts to share data and resources among the States. The MIA is an active member and leader of these efforts. The Compliance and Enforcement Section utilizes national databases, including the NAIC's Examination Tracking System, Producer Data Base, Complaint Data Base,

and the Regulatory Information Repository and the Special Activities Data Base. These efforts allow the Section to share and receive data and resources with other States.

Examinations present a representative picture of a company's current business practices and compliance with Maryland Laws and Regulations. Additionally, they help ensure a climate of fair competition and accessibility of coverage in the insurance marketplace. Combining the Units allows for a proactive approach of enforcement and regulation. The results of the Section's efforts for Fiscal Year 2003 are as follows:

Total Restitution (money returned to MD citizens) - $2,533,139
$1,144.216.80 - Agent Enforcement Unit
$809,556.20 - L/H Market Conduct Unit – ($691,000 from the Monumental Race Based Exam)
$579,366 - P&C Market Conduct Unit

Total Penalties (money paid to the General Fund) - $1,738,663
$10,000 - Agent Enforcement Unit
$1,064,858 - L/H Market Conduct Unit
$663,805 - P&C Market Conduct Unit

Total Per Diem Costs Billed to Companies (money paid to the Administration) - $1,322,522.88
$687,769.39 - L/H Market Conduct Unit
$634,753.49 - P&C Market Conduct Unit

Total Market Conduct Exams Opened - 38
20 - L/H Market Conduct Unit
18 - P&C Market Conduct Unit

Total Market Conduct Exams Closed - 33
15 - L/H Market Conduct Unit
18 - P&C Market Conduct Unit

Agent Investigations
575 - Cases Opened
482 - Cases Closed
31 - Orders of Revocation
32 - Orders (not including revocations)

Total Orders Issued - 101
63 - Agent Enforcement Unit
16 - L/H Market Conduct Unit
22 - P&C Market Conduct Unit

Orders, Consent Orders and Market Conduct Examination Reports are available on the MIA web site www.mdinsurance.state.md.us.

XII. Insurance Fraud Division

The Insurance Fraud Division (IFD) is responsible for the administration of insurance regulations concerning the efforts by licensed insurers to identify and counteract the effects of insurance fraud on their company and the insurance business. The Division is further responsible for the investigation of each person suspected of engaging in insurance fraud and referring suspected cases of insurance fraud to appropriate authorities for criminal prosecution. The Division is directed to exercise its authority by seeking cooperation with the Department of State Police, Office of the Attorney General and the Offices of the State's Attorney in all 24 subdivisions within the State of Maryland. In addition, the Division operates a toll free insurance fraud hot line and conducts public outreach and awareness programs on the costs of insurance fraud to the public.

The Insurance Fraud Division is comprised of three investigative sections.

Criminal Investigation Section
AGIT Investigation Section
Anti-Fraud Compliance Investigation Section

Criminal Investigation Section

The Criminal Investigation Section receives complaints from the insurance industry, private citizens, law enforcement agencies and other MIA enforcement units. Each complaint is screened for investigative potential. If there is enough information to proceed, detailed criminal investigations are conducted and staff works closely with prosecutors to bring the case to trial.

AGIT Investigation Section

The AGIT (Attorney General's Investigation Team) is comprised of insurance fraud investigators, State Police criminal investigators, and investigative auditors working in close cooperation with three Assistant Attorney's General. The section primarily handles complex or multi-jurisdictional cases and those complaints with a potentially high monetary loss. They also routinely review those complaints involving licensed entities, healthcare providers and other enforcement unit referrals.

Anti-Fraud Compliance Investigation Section

The Anti-Fraud Compliance Investigation Section was formed in January, 2001 to assume the background investigation duties previously conducted by the Licensing Compliance and Investigative Unit of the Licensing Section. This section conducts background investigations on officers, directors and major stockholders of insurance companies in Maryland as well as individuals involved with entities seeking a certificate of authority to conduct insurance business in Maryland. More compliance oversight is anticipated in the future.

The IFD enjoys an excellent working relationship with the Department of State Police, Office of the Attorney General as well as prosecutors and investigators in each of the local subdivisions in Maryland. The Division continues to develop working relationships with the United States Attorney's Office, the United States Postal Inspection Service, the Federal Bureau of Investigation, National Insurance Crime Bureau and other Federal law enforcement agencies

in the area. Regional development of cooperative investigation efforts are ongoing through the Mid Atlantic States Insurance Fraud Association and participation in the International Association of Certified Fraud Examiners (CFE) and the International Association of Special Investigation Units (IASIU).

The Fraud Division receives complaints from a variety of sources including insurance companies, law enforcement agencies, prosecutors, other state agencies and citizens. The Fraud Division operates a toll free reporting hotline to facilitate the reporting of suspected insurance fraud. The number of complaints fluctuates from year to year yet the number of investigations closed with criminal charges has remained over 100 for the past seven years with 126 and 122 for fiscal 2002 and 2003 respectively.

From July 1995 through June 2003, Insurance Fraud investigations have resulted in the conviction of over 440 individuals for insurance-related crimes

Prosecution Highlights – FY 2002

State vs. Burke Allen Walker

Following an investigation, Burke Walker, a licensed insurance agent for Gerling NCM Credit Insurance Company, was charged with the misappropriation of $556,981 in premiums collected on behalf of that company and diverting the money for his personal use. On August 21, 2002 he entered a guilty plea in the Circuit Court for Howard County to a one count criminal information, admitting that between October 16, 2000 and May 3, 2001 he misappropriated $556,981 in insurance premiums belonging to Gerling NCM. The Judge sentenced Walker to six years in the Division of Correction and suspended the sentence in favor of a five-year period of supervised probation. Walker was ordered to pay restitution in the amount of $423,941 to Gerling NCM. The restitution represents the amount of the premiums that he misappropriated minus the commission he was due as the agent involved in the sale of the policy.

State vs. Christina Scott

Christina Scott of Delmar obtained a full coverage automobile policy from Progressive Insurance Company covering her 1997 Chevrolet Blazer. As a condition of the policy Ms. Scott's husband, Darrell, was to be an excluded operator. Twenty-one days after the inception of the policy Ms. Scott contacted Progressive and reported that she swerved to avoid hitting a deer and had driven the vehicle into a ditch. A Progressive Insurance Company appraiser viewed the insured vehicle at the body shop to which it had been towed and determined that there was $10,726.20 damage to the vehicle. After appropriate review of the claim, Progressive paid the $10,726.20 and an additional $600 for vehicle rental. Later, Progressive received information that the loss may not have occurred as reported.

IFD investigation revealed that this incident actually occurred the day before Ms. Scott called the company for coverage. The accident occurred when a police officer attempted to stop the insured vehicle while Mr. Scott was operating it. Mr. Scott fled and attempted to elude the officer by driving at a high rate of speed and crossing into Delaware. While on Rt. 54 in Delaware, he lost control of the vehicle and crashed into a ditch. Mr. Scott was arrested and charged with numerous traffic violations. After uncovering this information, charges of Felony Insurance Fraud and Felony Theft were placed against Christina Scott in Wicomico County.

Ms. Scott subsequently pled guilty. She was sentenced to serve five years incarceration with all but 18 months suspended. After her release from prison Ms. Scott was ordered to serve 36 months supervised probation during which time she was ordered to make restitution to Progressive Insurance Company in the amount of $11,326.20.

State vs. Edwin J. Kirby, Jr. d/b/a Banker's Title Company

As early as 1993, Edwin Kirby began taking money out of Bankers Title escrow accounts to cover the company's operating costs as well as certain personal expenditures. Kirby was able to avoid detection by maintaining three separate escrow accounts. When title insurers would come to review financial records, he would show them the records of only one escrow account, transferring money from the other accounts to make it appear as if there were funds available to meet all escrow obligations. A forensic audit conducted by the IFD revealed that from 1997 until the company closed in February 2000 there were literally hundreds of money transfers between accounts.

Kirby pled guilty in Baltimore County Circuit Court to stealing over $1,200,000 from the escrow accounts. He was sentenced to eight years incarceration with all but nine months suspended. Upon his release, Kirby will be on probation for five years. As a condition of that probation, the court ordered him to continue to pay $700 per month in restitution.

State vs. Gerald Miller

Gerald Miller was terminated as an insurance agent for United America Insurance Company on July 30, 2001. During the months that followed, Miller went to the residence of several elderly former clients and told them that they had premium payments due. Miller explained that if they did not make payment to him immediately, their health insurance would be cancelled. If the client did not have cash on hand Miller would coerce them into going to an ATM for the money. As a result of his activities, Miller was charged with felony insurance fraud and felony theft in a 22 count criminal indictment.

On May 13, 2002, in the Circuit Court for Baltimore County, Miller pled guilty to the charges. The Judge ordered a pre-sentence investigation. During sentencing on July 25, 2002 the Judge noted that Miller had chosen to victimize vulnerable senior citizens ranging in age from 84 to 94 years of age. He sentenced Miller to 20 years in prison and suspended 10 years. After completing of his 10 year sentence, Miller will be required to serve five years supervised probation. He was also ordered to make restitution to his victims.

Statistical Data – FY 2002

Written Complaints Received	1,084
Electronic Complaints Received	288
Telephone Tips	302
Total # Complaints Received	**1,674**
Complaint Resolutions	
Number Closed at Initial Screening	884
Number Closed Without Prosecution Referral	104
Number Referred to MIA	69
Number Referred to Other Law Enforcement	50
Number Referred for Inquiry to Insurer	119
Total Number Opened for Investigation	**324**

Cases referred to Area State's Attorneys for Prosecution	134
Charged	114
Prosecution declined	10
Pending Review	10
Cases Referred to Division Attorneys General	55
Opened for investigation by AGIT	33
Returned to IFD for investigation	5
Returned to IFD/recommended closure	17
Investigations closed by filing charges	12
Individuals charged	12
Cases Referred to Division State Police	13
Cases Closed with Charges Filed	6
Open Investigations	7
Calls Received on Fraud Hotline	302
Complaints Received From Regulated Entities	1,300

Total Number of Cases By Insurance Type

Agent/Broker Fraud	41
Personal Injury -Auto	228
Personal Injury - Other	33
Health Care Provider Fraud	26
Health Insurance Fraud	13
False Application Fraud	60
Property Claim Fraud - Other	162
Property Claim Fraud – Auto Theft, etc.	384
Worker Compensation Fraud - Claimant	169
Insurer Fraud	6
Life Insurance Fraud	5
Medical Provider Fraud	0
Adjuster/Employee Fraud	7
Other Fraud	248
MAIF Residency Fraud	292

Investigation Highlights – FY 2003

NICB Medical Fraud Working Group

Since February 2003, the IFD has participated as an initial member in the Maryland Medical Fraud Working Group organized by the National Insurance Crime Bureau. This working group is a cooperative effort involving the insurance industry, local law enforcement, federal law enforcement, local and state prosecutors and other support agencies from several states and the District of Columbia. The purpose is to identify medical fraud trends and seek a cooperative effort between the insurance industry, law enforcement and prosecutors in the investigation and prosecution of medical fraud on a regional basis.

Regional Auto Theft Taskforce (RATT)

In FY 2003, the IFD formed an investigative alliance with the Regional Auto Theft Taskforce (RATT) to counteract the increasing trend of auto theft for profit through insurance claims. This cooperative effort involves the joint concurrent investigation of auto thefts and associated insurance claims by RATT law enforcement officers and Fraud Division investigators.

Known as “giveups”, a growing number of vehicle owners, especially leased vehicle owners, seek to avoid expensive payments and penalties or costly repairs by purposely having these vehicles stolen. Vehicles are then hidden, resold, chopped for parts or otherwise destroyed with the knowledge of the owner. Subsequent insurance claims pay off loans or leases before the true circumstances of the theft are known. In the past, such claims went undetected by the insurer. From the onset of this project, a total of 16 insurance fraud cases were opened and closed with criminal charges from complaints received from the Regional Auto Theft Taskforce.

Pro-Active Operations

Upon request, the Criminal Investigation Section offered technical support to local law enforcement officers in criminal charging procedures for violations of the Fraudulent Insurance Act. Division investigators assisted law enforcement investigators by providing expertise in consensual monitoring operations associated with insurance fraud cases. Most of the RATT cases involved this investigative technique of monitoring conversations between investigators and claim participants to further the investigations. Also, Divisional investigators continue to participate in investigations with several insurer Special Investigation Units (SIU) requiring the use of these monitoring skills and other covert operation techniques.

Division investigative staff participates in the Montgomery County Stolen Burned Auto Taskforce involving the issue of the escalating trend of vehicle theft with arson incidents where owner “giveups” for insurance claim purposes are being identified as motivating factors. Similarly, investigators have participated in discussions with law enforcement officials attempting to organize a Prince George’s County RATT.

Prosecution Highlights – FY 2003

State vs. Richard G. Halpern

Richard G. Halpern was a licensed pharmacist and the owner operator of Irvin’s Pharmacy in Lansdowne. Between 1994 and 1996, he billed various insurance companies for pharmaceutical products that he never actually dispensed. As a result of this scheme, Halpern received in excess of $309,000 in illegitimate insurance reimbursements. Following the IFD’s investigation, Halpern was charged with a number of felony counts.

On August 21, 2002, Halpern pled guilty to one count of Felony Insurance Fraud in the Circuit Court of Baltimore County. On October 29, 2002, the judge sentenced Halpern to seven years of incarceration with all but six months suspended. He also placed Halpern of five years supervised probation and ordered that he make restitution in the amount of $309,589.

State vs. Johnathan Mosley

After a jury trail in the Circuit Court of Baltimore County, Johnathan Mosley was convicted of four counts of felony insurance fraud. Evidence was presented that Mosley, who was employee by the Department of Juvenile Justice as an Addiction Counselor, submitted fraudulent documentation in support of a personal injury insurance claim. The false submissions included a letter and other documents, purportedly from the Department of Juvenile Justice that misclassified his position, misrepresented his salary, and falsely indicated that he missed three months of work. Mosley also created and submitted fraudulent W-2 tax forms to support a lost wage claim concerning a private business that allegedly owned.

On March 6, 2003, Mosley was sentenced to five years of incarceration. That sentence was suspended in favor of 18 months of supervised probation. He was also ordered to perform 112 hours of community service.

State vs. Dennis Heflin

On August 11, 1997, Dennis Heflin submitted an application for long-term disability benefits to the Hartford Insurance Company claiming that he had been injured and was unable to work. During his alleged disability Heflin received $63,066 in disability benefits payments from the Hartford. The Hartford developed information that led them to believe that Heflin was actually employed during his period of disability and the forwarded that information to the IFD. After an investigation that revealed that Heflin had worked as a route salesman for two companies, he was charged in a two-count indictment with Insurance Fraud.

In April 2003 in the Circuit Court for Wicomico County, Heflin pled not guilty and chose to be tried by a jury. He was subsequently convicted of both counts of insurance fraud. On April 17, 2003, Heflin was sentenced to five years and six months in prison. He suspended five years and ordered that Heflin complete five years of supervised probation after he completed his jail time. He also ordered that Heflin make restitution in the amount of $63,066 to the Hartford Insurance Company.

All the cases highlighted for FY 2002 and FY 2003 were prosecuted by prosecutors from the Office of the Attorney General who are assigned to the Insurance Fraud Division

Statistical data – FY 2003

Written Complaints Received	967
Electronic Complaints Received	328
Telephone Tips	283
Total Complaints received	**1,578**

Complaint Resolutions

Number Closed at Initial Screening	837
Number Closed Without Prosecution Referral	73
Number Referred to MIA	54
Number Referred to Other Law Enforcement	39
Number Referred for Inquiry to Insurer	120
Total Number Opened for Investigation	**374**
Cases Referred to Area State's Attorneys for Prosecution	149
Charged	109
Prosecution declined	30
Pending Review	10
Cases Referred to Division Attorneys General	88
Opened for investigation by AGIT	63
Returned to IFD for investigation	8
Returned to IFD/recommended closure	22
Investigations closed by filing charges	13
Individuals charged	14

Cases Referred to Division of State Police		23
Cases Closed with Charges Filed		3
Cases Closed with Charges Filed (AGIT)		10
Cases Closed – No Charges Filed		4
Open Investigations		16
Calls Received on Fraud Hotline		283
Complaints Received From Regulated Entities		1,230
Total Number of Cases By Insurance Fraud Type		
Agent/Broker Fraud	37	
Personal Injury - Auto	242	
Personal; Injury - Other	38	
Healthcare Provider Fraud	24	
Health insurance Fraud	11	
False Application Fraud	70	
Property Claim Fraud - Other	130	
Property Claim Fraud – Auto Theft, etc.	285	
Worker Compensation Fraud - Claimant	170	
Insurer Fraud	6	
Life Insurance Fraud	7	
Medical Provider Fraud	2	
Adjuster/Employee Fraud	7	
Other Fraud	258	
MAIF Residency Fraud	291	