Chapter 120

(House Bill 69)

AN ACT concerning

Insurance – Insurers – Audits, Investments, and Operations

FOR the purpose of authorizing the Maryland Insurance Commissioner to require a health maintenance organization, authorized insurer, nonprofit health service plan, dental plan organization, and managed care organization to file certain audited financial reports earlier than certain dates; prohibiting certain partners in certain accounting firms responsible for preparing certain audited financial reports from acting in that capacity for more than a certain number of consecutive years for the same insurer; requiring certain insurers to file with the Commissioner certain written plans and all changes and amendments to the written plans for use in the State on or before a certain date; authorizing the reserve investments of an insurer to include securities lending, repurchase, reverse purchase, and dollar roll transactions with business entities, subject to certain requirements; clarifying the type of information that the Commissioner may consider in determining whether the continued operation of an authorized insurer engaging in insurance business in the State would be hazardous to policyholders or creditors of the authorized insurer or the general public; authorizing the Commissioner to order certain insurers to take certain actions if the Commissioner determines that the continued operation of an authorized insurer may be hazardous to policyholders or creditors of the authorized insurer or the general public; requiring the annual statement filed by each nonprofit health service plan to be in a certain form and to contain certain additional information; requiring each nonprofit health service plan to file a certain audited financial report; requiring each nonprofit health service plan to file a certain audited financial report for each affiliate and subsidiary owned by or under the control of the nonprofit health service plan; clarifying the form and content of the annual statement filed by a dental plan organization; authorizing the Commissioner to require a dental plan organization doing business in the State to file a certain interim statement containing certain information; requiring a dental plan organization to file a certain audited financial report; establishing certain penalties; defining certain terms; and generally relating to the audits, investments, and operations of insurers.

BY adding to
Article – Health – General
Section 19–706(cccc)
Annotated Code of Maryland
(2009 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–717
Annotated Code of Maryland
(2009 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 4–116(c), 4–118(c)(1), 5–511(n), 5–608(a) and (t), 9–102, and 9–103
Annotated Code of Maryland
(2003 Replacement Volume and 2009 Supplement)

BY adding to
Article – Insurance
Section 4–116(d) and 5–608(t)
Annotated Code of Maryland
(2003 Replacement Volume and 2009 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–121, 14–413, and 15–605(f)
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

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

Article – Health – General

19–706.

(CCCC) THE PROVISIONS OF § 5–608(T) OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19–717.

(a) Except as provided in **[**subsection (b)**]** **SUBSECTIONS (B) AND (C)** of this section and unless, for good cause shown, the Commissioner extends the time for a reasonable period:

(1) On or before March 1 of each year, each health maintenance organization shall file with the Commissioner a report that shows the financial condition of the health maintenance organization on the last day of the preceding calendar year and any other information that the Commissioner requires by rule or regulation; and

(2) On or before June 1 of each year, each health maintenance organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(b) A health maintenance organization that has a fiscal year other than the calendar year may request permission to file both the annual report required under subsection (a)(1) of this section and the audited financial report required under subsection (a)(2) of this section at the end of its fiscal year rather than the preceding calendar year. If the Commissioner grants this permission, the health maintenance organization shall file the annual report with the Commissioner within 60 days after the end of its fiscal year, and the health maintenance organization shall file the audited financial report with the Commissioner within 150 days after the end of its fiscal year.

(C) WITH 90 DAYS' ADVANCE NOTICE, THE COMMISSIONER MAY REQUIRE A HEALTH MAINTENANCE ORGANIZATION TO FILE AN AUDITED FINANCIAL REPORT EARLIER THAN THE DATE SPECIFIED IN SUBSECTION (A) OF THIS SECTION.

[(c)**] (D)** The annual report shall:

(1) Be on the forms that the Commissioner requires; and

(2) Include a description of any changes in the information submitted under § 19–708 of this subtitle.

[(d)**] (E)** The audited financial report shall:

(1) Be on the forms that the Commissioner requires; and

(2) Be certified by an audit of a certified public accounting firm.

[(e)**] (F)** Each financial report filed under this section is a public record.

Article – Insurance

4–116.

(c) (1) **[**On**] EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, ON** or before June 1 of each year, an authorized insurer shall file with the Commissioner an audited financial report for the immediately preceding calendar year.

(2) The authorized insurer shall have the report prepared by an independent certified public accountant.

(3) The Commissioner may:

(i) set requirements for the form and content of the report; and

(ii) for good cause, extend the time for filing the report.

(4) Unless the Commissioner extends the time for filing, an authorized insurer that fails to file an audited financial report on or before June 10 shall pay a penalty of:

(i) $100 for each day from June 1 to June 10, both inclusive; and

(ii) $150 for each day from June 11 to the day before the Commissioner receives the report, both inclusive.

(D) WITH 90 DAYS' ADVANCE NOTICE, THE COMMISSIONER MAY REQUIRE AN AUTHORIZED INSURER TO FILE AN AUDITED FINANCIAL REPORT EARLIER THAN THE DATE SPECIFIED IN SUBSECTION (C) OF THIS SECTION.

4–118.

(c) (1) (i) A partner in an accounting firm responsible for preparing an audited financial report under § 4–116 of this subtitle for an insurer may not act in that capacity for more than **[**7**]** **5** consecutive years for the same insurer.

(ii) If a partner in an accounting firm responsible for preparing an audited financial report under § 4–116 of this subtitle for an insurer exceeds **[**7**]** **5** consecutive years in that capacity, the partner shall be disqualified from acting in the same or similar capacity for that insurer or its insurance subsidiaries or affiliates for a period of not less than **[**2**]** **5 CONSECUTIVE** years.

5–511.

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

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

[(i)**]** **1.** a description of how cash received will be invested or used for general corporate purposes of the insurer;

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

[(iii)**]** **3.** the extent to which the insurer may engage in these transactions.

(II) THE INSURER SHALL FILE WITH THE COMMISSIONER THE WRITTEN PLAN INCLUDING ALL CHANGES AND AMENDMENTS TO THE WRITTEN PLAN FOR USE IN THE STATE ON OR BEFORE THE DATE THE PLAN BECOMES EFFECTIVE.

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

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

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

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

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

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

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

1. possession of the acceptable collateral;

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

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

(5) (i) The limitations of § 5–507 of this subtitle do not apply to the business entity counterparty exposure created by transactions under this subsection.

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

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

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

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

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

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

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

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

(ii) If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities so transferred, the business

entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 95% of the market value of the transferred securities.

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

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

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

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

5–608.

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

(2) "DOLLAR ROLL TRANSACTION" MEANS TWO SIMULTANEOUS TRANSACTIONS WITH DIFFERENT SETTLEMENT DATES NO MORE THAN 96 DAYS APART, SO THAT IN THE TRANSACTION WITH THE EARLIER SETTLEMENT DATE, AN INSURER SELLS TO A BUSINESS ENTITY, AND IN THE OTHER TRANSACTION THE INSURER IS OBLIGATED TO PURCHASE FROM THE SAME BUSINESS ENTITY, SUBSTANTIALLY SIMILAR SECURITIES OF THE FOLLOWING TYPES:

(I) ASSET–BACKED SECURITIES ISSUED, ASSUMED, OR GUARANTEED BY THE GOVERNMENT NATIONAL MORTGAGE ASSOCIATION, THE FEDERAL NATIONAL MORTGAGE ASSOCIATION, OR THE FEDERAL HOME LOAN MORTGAGE CORPORATION OR THEIR RESPECTIVE SUCCESSORS; AND

(II) OTHER ASSET–BACKED SECURITIES REFERRED TO IN SECTION 106 OF TITLE I OF THE SECONDARY MORTGAGE MARKET ENHANCEMENT ACT OF 1984 (15 U.S.C., § 77R–1), AS AMENDED.

[(2)**] (3)** "Fixed charges" include:

(i) interest on funded and unfunded debt amortization of debt discount; and

(ii) rentals for leased properties.

[(3)**] (4)** "Institution" includes a corporation, joint stock association, and business trust.

[(4)**] (5)** "Net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes other than federal and state income taxes, depreciation, and depletion, and excluding extraordinary nonrecurring items or income or expense appearing in the regular financial statements of the issuing, assuming, or guaranteeing institutions.

[(5)**] (6)** "Obligation" includes bonds, debentures, notes, or other evidences of indebtedness.

(7) "REPURCHASE TRANSACTION" MEANS A TRANSACTION IN WHICH AN INSURER PURCHASES SECURITIES FROM A BUSINESS ENTITY THAT IS OBLIGATED TO REPURCHASE THE PURCHASED SECURITIES OR EQUIVALENT SECURITIES FROM THE BUSINESS ENTITY AT A SPECIFIED PRICE, EITHER WITHIN A SPECIFIED PERIOD OF TIME OR ON DEMAND.

(8) "REVERSE REPURCHASE TRANSACTION" MEANS A TRANSACTION IN WHICH AN INSURER SELLS SECURITIES TO A BUSINESS ENTITY AND IS OBLIGATED TO REPURCHASE THE SOLD SECURITIES OR EQUIVALENT SECURITIES FROM THE BUSINESS ENTITY AT A SPECIFIED PRICE, EITHER WITHIN A SPECIFIED PERIOD OF TIME OR ON DEMAND.

(9) "SECURITIES LENDING TRANSACTION" MEANS A TRANSACTION IN WHICH SECURITIES ARE LOANED BY AN INSURER TO A BUSINESS ENTITY THAT IS OBLIGATED TO RETURN THE LOANED SECURITIES OR EQUIVALENT SECURITIES TO THE INSURER, EITHER WITHIN A SPECIFIED PERIOD OF TIME OR ON DEMAND.

(T) (1) THE RESERVE INVESTMENTS OF AN INSURER MAY INCLUDE SECURITIES LENDING, REPURCHASE, REVERSE REPURCHASE, AND DOLLAR ROLL TRANSACTIONS WITH BUSINESS ENTITIES, SUBJECT TO THE REQUIREMENTS OF PARAGRAPHS (2) THROUGH (9) OF THIS SUBSECTION.

(2) (I) THE INSURER'S BOARD OF DIRECTORS SHALL ADOPT A WRITTEN PLAN THAT SPECIFIES GUIDELINES AND OBJECTIVES TO BE FOLLOWED, SUCH AS:

1. A DESCRIPTION OF HOW CASH RECEIVED WILL BE INVESTED OR USED FOR GENERAL CORPORATE PURPOSES OF THE INSURER;

2. OPERATIONAL PROCEDURES TO MANAGE INTEREST RATE RISK, COUNTERPARTY DEFAULT RISK, THE CONDITIONS UNDER WHICH PROCEEDS FROM REVERSE REPURCHASE TRANSACTIONS MAY BE USED IN THE ORDINARY COURSE OF BUSINESS, AND THE USE OF ACCEPTABLE COLLATERAL IN A MANNER THAT REFLECTS THE LIQUIDITY NEEDS OF THE TRANSACTION; AND

3. THE EXTENT TO WHICH THE INSURER MAY ENGAGE IN THESE TRANSACTIONS.

(II) THE INSURER SHALL FILE WITH THE COMMISSIONER THE WRITTEN PLAN INCLUDING ALL CHANGES AND AMENDMENTS TO THE WRITTEN PLAN FOR USE IN THE STATE ON OR BEFORE THE DATE THE PLAN BECOMES EFFECTIVE.

(3) (I) THE INSURER SHALL ENTER INTO A WRITTEN AGREEMENT FOR ALL TRANSACTIONS AUTHORIZED UNDER THIS SUBSECTION OTHER THAN DOLLAR ROLL TRANSACTIONS.

(II) THE WRITTEN AGREEMENT SHALL REQUIRE THAT EACH TRANSACTION TERMINATE NO MORE THAN 1 YEAR FROM ITS INCEPTION OR ON THE EARLIER DEMAND OF THE INSURER.

(III) THE AGREEMENT SHALL BE WITH THE BUSINESS ENTITY COUNTERPARTY, BUT FOR SECURITIES LENDING TRANSACTIONS, THE AGREEMENT MAY BE WITH AN AGENT ACTING ON BEHALF OF THE INSURER, IF THE AGENT IS A QUALIFIED BUSINESS ENTITY, AND IF THE AGREEMENT:

1. REQUIRES THE AGENT TO ENTER INTO SEPARATE AGREEMENTS WITH EACH COUNTERPARTY THAT ARE CONSISTENT WITH THE REQUIREMENTS OF THIS SECTION; AND

2. PROHIBITS SECURITIES LENDING TRANSACTIONS UNDER THE AGREEMENT WITH THE AGENT OR ITS AFFILIATES.

(4) (I) CASH RECEIVED IN A TRANSACTION UNDER THIS SUBSECTION SHALL BE INVESTED IN ACCORDANCE WITH THIS SUBTITLE AND IN A MANNER THAT RECOGNIZES THE LIQUIDITY NEEDS OF THE TRANSACTION OR USED BY THE INSURER FOR ITS GENERAL CORPORATE PURPOSES.

(II) FOR SO LONG AS THE TRANSACTION REMAINS OUTSTANDING, THE INSURER, ITS AGENT, OR ITS CUSTODIAN SHALL MAINTAIN, AS TO ACCEPTABLE COLLATERAL RECEIVED IN A TRANSACTION UNDER THIS SUBSECTION, EITHER PHYSICALLY OR THROUGH THE BOOK ENTRY SYSTEMS OF THE FEDERAL RESERVE, DEPOSITORY TRUST COMPANY, PARTICIPANTS TRUST COMPANY, OR OTHER SECURITIES DEPOSITORIES APPROVED BY THE COMMISSIONER:

1. POSSESSION OF THE ACCEPTABLE COLLATERAL;

2. A PERFECTED SECURITY INTEREST IN THE ACCEPTABLE COLLATERAL; OR

3. IN THE CASE OF A JURISDICTION OUTSIDE THE UNITED STATES, TITLE TO, OR RIGHTS OF A SECURED CREDITOR TO, THE ACCEPTABLE COLLATERAL.

(5) (I) THE LIMITATIONS OF § 5–606(A) OF THIS SUBTITLE DO NOT APPLY TO THE BUSINESS ENTITY COUNTERPARTY EXPOSURE CREATED BY TRANSACTIONS UNDER THIS SUBSECTION.

(II) FOR PURPOSES OF CALCULATIONS MADE TO DETERMINE COMPLIANCE WITH THIS SUBSECTION, NO EFFECT WILL BE GIVEN TO THE INSURER'S FUTURE OBLIGATION TO RESELL SECURITIES, IN THE CASE OF A REPURCHASE TRANSACTION, OR TO REPURCHASE SECURITIES, IN THE CASE OF A REVERSE REPURCHASE TRANSACTION.

(III) AN INSURER MAY NOT ENTER INTO A TRANSACTION UNDER THIS SUBSECTION IF, AS A RESULT OF AND AFTER GIVING EFFECT TO THE TRANSACTION:

1. A. THE AGGREGATE AMOUNT OF SECURITIES THEN LOANED, SOLD TO, OR PURCHASED FROM ANY ONE BUSINESS ENTITY COUNTERPARTY UNDER THIS SUBSECTION WOULD EXCEED 5% OF ITS ADMITTED ASSETS; AND

B. IN CALCULATING THE AMOUNT SOLD TO OR PURCHASED FROM A BUSINESS ENTITY COUNTERPARTY UNDER REPURCHASE OR REVERSE REPURCHASE TRANSACTIONS, EFFECT MAY BE GIVEN TO NETTING PROVISIONS UNDER A MASTER WRITTEN AGREEMENT; OR

2. THE AGGREGATE AMOUNT OF ALL SECURITIES THEN LOANED, SOLD TO, OR PURCHASED FROM ALL BUSINESS ENTITIES UNDER THIS SUBSECTION WOULD EXCEED 40% OF ITS ADMITTED ASSETS.

(6) (I) IN A SECURITIES LENDING TRANSACTION, THE INSURER SHALL RECEIVE ACCEPTABLE COLLATERAL HAVING A MARKET VALUE AS OF THE TRANSACTION DATE AT LEAST EQUAL TO 102% OF THE MARKET VALUE OF THE SECURITIES LOANED BY THE INSURER IN THE TRANSACTION AS OF THAT DATE.

(II) IF AT ANY TIME THE MARKET VALUE OF THE ACCEPTABLE COLLATERAL IS LESS THAN THE MARKET VALUE OF THE LOANED SECURITIES, THE BUSINESS ENTITY COUNTERPARTY SHALL BE OBLIGATED TO DELIVER ADDITIONAL ACCEPTABLE COLLATERAL, THE MARKET VALUE OF WHICH, TOGETHER WITH THE MARKET VALUE OF ALL ACCEPTABLE COLLATERAL THEN HELD IN CONNECTION WITH THE TRANSACTION, AT LEAST EQUALS 102% OF THE MARKET VALUE OF THE LOANED SECURITIES.

(7) (I) IN A REVERSE REPURCHASE TRANSACTION, OTHER THAN A DOLLAR ROLL TRANSACTION, THE INSURER SHALL RECEIVE ACCEPTABLE COLLATERAL HAVING A MARKET VALUE AS OF THE TRANSACTION DATE AT LEAST EQUAL TO 95% OF THE MARKET VALUE OF THE SECURITIES TRANSFERRED BY THE INSURER IN THE TRANSACTION AS OF THAT DATE.

(II) IF AT ANY TIME THE MARKET VALUE OF THE ACCEPTABLE COLLATERAL IS LESS THAN 95% OF THE MARKET VALUE OF THE SECURITIES SO TRANSFERRED, THE BUSINESS ENTITY COUNTERPARTY SHALL BE OBLIGATED TO DELIVER ADDITIONAL ACCEPTABLE COLLATERAL, THE MARKET VALUE OF WHICH, TOGETHER WITH THE MARKET VALUE OF ALL ACCEPTABLE COLLATERAL THEN HELD IN CONNECTION WITH THE TRANSACTION, AT LEAST EQUALS 95% OF THE MARKET VALUE OF THE TRANSFERRED SECURITIES.

(8) IN A DOLLAR ROLL TRANSACTION, THE INSURER SHALL RECEIVE CASH IN AN AMOUNT AT LEAST EQUAL TO THE MARKET VALUE OF THE SECURITIES TRANSFERRED BY THE INSURER IN THE TRANSACTION AS OF THE TRANSACTION DATE.

(9) (I) IN A REPURCHASE TRANSACTION, THE INSURER SHALL RECEIVE AS ACCEPTABLE COLLATERAL TRANSFERRED SECURITIES HAVING A MARKET VALUE AT LEAST EQUAL TO 102% OF THE PURCHASE PRICE PAID BY THE INSURER FOR THE SECURITIES.

(II) IF AT ANY TIME THE MARKET VALUE OF THE ACCEPTABLE COLLATERAL IS LESS THAN 100% OF THE PURCHASE PRICE PAID BY THE INSURER, THE BUSINESS ENTITY COUNTERPARTY SHALL BE OBLIGATED TO PROVIDE ADDITIONAL ACCEPTABLE COLLATERAL, THE MARKET VALUE OF WHICH, TOGETHER WITH THE MARKET VALUE OF ALL ACCEPTABLE COLLATERAL THEN HELD IN CONNECTION WITH THE TRANSACTION, AT LEAST EQUALS 102% OF THE PURCHASE PRICE.

(III) SECURITIES ACQUIRED BY AN INSURER IN A REPURCHASE TRANSACTION MAY NOT BE SOLD IN A REVERSE REPURCHASE TRANSACTION, LOANED IN A SECURITIES LENDING TRANSACTION, OR OTHERWISE PLEDGED.

[(t)**] (U)** The reserve investments of an insurer may include any other investments not otherwise prohibited by this subtitle if:

(1) the aggregate amount of the investments made under this subsection does not exceed 4% of the amount of the admitted assets of the insurer at the end of the previous year; and

(2) the investment does not violate any limitations on allowed investments under this section.

9–102.

(a) In determining whether the continued operation of an authorized insurer engaging in insurance business in the State would be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may consider:

(1) adverse findings reported in financial condition and market conduct examination reports**, AUDIT REPORTS, AND ACTUARIAL OPINIONS, REPORTS, OR SUMMARIES**;

(2) the Insurance Regulatory Information System and **[**related reports**] OTHER FINANCIAL ANALYSIS SOLVENCY TOOLS AND REPORTS** of the National Association of Insurance Commissioners;

(3) **[**the ratios of benefits under policies, reserve increases, commission expense, and general insurance expense, as to annual premium and net investment income and whether any of those ratios could lead to an impairment of capital and surplus;

(4) whether the asset portfolio of the authorized insurer, when viewed in light of current economic conditions, has sufficient value, liquidity, or diversity to

ensure the ability of the authorized insurer to meet its outstanding obligations as they mature**] WHETHER THE AUTHORIZED INSURER HAS MADE ADEQUATE PROVISION, ACCORDING TO PRESENTLY ACCEPTED ACTUARIAL STANDARDS OF PRACTICE, FOR THE ANTICIPATED CASH FLOWS REQUIRED BY THE CONTRACTUAL OBLIGATIONS AND RELATED EXPENSES OF THE INSURER, WHEN CONSIDERED IN LIGHT OF THE ASSETS HELD BY THE INSURER WITH RESPECT TO SUCH RESERVES AND RELATED ACTUARIAL ITEMS INCLUDING, BUT NOT LIMITED TO, THE INVESTMENT EARNINGS ON SUCH ASSETS AND THE CONSIDERATIONS ANTICIPATED TO BE RECEIVED AND RETAINED UNDER SUCH POLICIES AND CONTRACTS**;

[(5)**] (4)** the ability of an assuming reinsurer to perform, including whether the reinsurance program of the authorized insurer provides sufficient protection for its remaining surplus, after taking into account the cash flow of the authorized insurer and classes of business written by the authorized insurer and the financial condition of the assuming reinsurer;

[(6)**] (5)** whether in the last 12–month period or any shorter period, the authorized insurer's operating loss, calculated to include net capital gain or loss, change in non–admitted assets, and cash dividends paid to stockholders, is greater than 50% of that part of the authorized insurer's policyholder surplus that is in excess of the minimum required surplus;

(6) WHETHER THE AUTHORIZED INSURER'S OPERATING LOSS IN THE LAST 12–MONTH PERIOD OR ANY SHORTER PERIOD, EXCLUDING NET CAPITAL GAINS, IS GREATER THAN 20% OF THE AUTHORIZED INSURER'S POLICYHOLDER SURPLUS THAT IS IN EXCESS OF THE MINIMUM REQUIRED SURPLUS;

(7) whether **[**an affiliate, subsidiary, or**] A** reinsurer**, OBLIGOR, OR ANY ENTITY WITHIN THE AUTHORIZED INSURER'S INSURANCE HOLDING SYSTEM** is insolvent, threatened with insolvency, or delinquent in the payment of a monetary or other obligation**, AND WHICH, IN THE OPINION OF THE COMMISSIONER, MAY AFFECT THE SOLVENCY OF THE INSURER**;

(8) contingent liabilities, pledges, or guarantees that, either individually or collectively, involve a total amount that the Commissioner believes may affect the solvency of the authorized insurer;

(9) whether a controlling person of the authorized insurer is delinquent in transmission or payment of net premiums to the insurer;

(10) the age and collectibility of receivables;

(11) whether the management of the authorized insurer, including an officer, director, or any other person that has direct or indirect control over operation, fails to possess and demonstrate the competence, fitness, and reputation considered necessary to serve the authorized insurer in a position of control;

(12) whether the management of the authorized insurer has failed to respond to inquiries about the condition of the authorized insurer or has responded to an inquiry with false or misleading information;

(13) WHETHER THE AUTHORIZED INSURER HAS FAILED TO MEET FINANCIAL AND HOLDING COMPANY FILING REQUIREMENTS IN THE ABSENCE OF A REASON SATISFACTORY TO THE COMMISSIONER;

[(13)**] (14)** whether the management of the authorized insurer has:

(i) filed a false or misleading sworn financial statement;

(ii) released a false or misleading financial statement to a lending institution or the general public;

(iii) made a false or misleading entry in the books of the authorized insurer; or

(iv) omitted an entry of a material amount in the books of the authorized insurer;

[(14)**] (15)** whether the authorized insurer has grown so rapidly that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; **[**or**]**

[(15)**] (16)** whether the authorized insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems**;**

(17) WHETHER THE MANAGEMENT OF AN AUTHORIZED INSURER HAS ESTABLISHED RESERVES THAT DO NOT COMPLY WITH MINIMUM STANDARDS ESTABLISHED BY THE STATE'S INSURANCE LAWS, STATUTORY ACCOUNTING STANDARDS, SOUND ACTUARIAL PRINCIPLES, AND STANDARDS OF PRACTICE;

(18) WHETHER THE MANAGEMENT OF AN AUTHORIZED INSURER PERSISTENTLY ENGAGES IN MATERIAL UNDER–RESERVING THAT RESULTS IN ADVERSE DEVELOPMENT;

(19) WHETHER TRANSACTIONS AMONG AFFILIATES, SUBSIDIARIES, OR CONTROLLING PERSONS FOR WHICH THE INSURER RECEIVES ASSETS OR CAPITAL GAINS, OR BOTH, DO NOT PROVIDE SUFFICIENT VALUE, LIQUIDITY, OR DIVERSITY TO ASSURE THE AUTHORIZED INSURER'S ABILITY TO MEET ITS OUTSTANDING OBLIGATIONS AS THEY MATURE; OR

(20) ANY OTHER FINDING DETERMINED BY THE COMMISSIONER TO BE HAZARDOUS TO POLICYHOLDERS, CREDITORS OF THE AUTHORIZED INSURER, OR THE GENERAL PUBLIC.

(b) In determining whether the financial condition of an authorized insurer would cause its continued operation in the State to be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may:

(1) disregard a credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments**, INCLUDING DISALLOWANCE, CONSISTENT WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS ACCOUNTING POLICIES AND PROCEDURES MANUAL AND STATE LAWS AND REGULATIONS,** to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates of the authorized insurer;

(3) refuse to recognize the stated value of accounts receivable if the ability to collect the receivables is highly speculative because of the age of the account or financial condition of the debtor; or

(4) increase the liability of the authorized insurer in an amount equal to any contingent liability, pledge, or guarantee not otherwise included in the statement of liability if there is a substantial risk that the authorized insurer will have to discharge the liability, pledge, or guarantee within the next 12–month period.

9–103.

If the Commissioner determines that the continued operation of an authorized insurer may be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may issue an order that requires the authorized insurer to:

(1) reduce the total amount of present and potential liability for benefits under policies through reinsurance;

(2) reduce, suspend, or limit the volume of business being accepted or renewed;

(3) reduce general insurance and commission expenses by specified methods;

(4) increase capital and surplus;

(5) suspend or limit the declaration and payment of dividends to policyholders or stockholders;

(6) file reports in a form acceptable to the Commissioner about the market value of its assets;

(7) limit or withdraw from certain investments or discontinue certain investment practices to the extent that the Commissioner considers necessary;

(8) document the adequacy of premium rates in relation to risks insured; **[**or**]**

(9) file, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in another form required by the Commissioner**;**

(10) CORRECT CORPORATE GOVERNANCE PRACTICE DEFICIENCIES AND ADOPT AND UTILIZE GOVERNANCE PRACTICES ACCEPTABLE TO THE COMMISSIONER;

(11) PROVIDE A BUSINESS PLAN TO THE COMMISSIONER IN ORDER TO CONTINUE TO TRANSACT BUSINESS IN THE STATE; OR

(12) NOTWITHSTANDING ANY OTHER PROVISION OF LAW LIMITING THE FREQUENCY OR AMOUNT OF PREMIUM RATE ADJUSTMENTS, ADJUST RATES FOR ANY NONLIFE INSURANCE PRODUCT WRITTEN BY THE AUTHORIZED INSURER THAT THE COMMISSIONER CONSIDERS NECESSARY TO IMPROVE THE FINANCIAL CONDITION OF THE INSURER.

14–121.

(a) (1) On or before March 1 of each year, unless the Commissioner extends the time for good cause, each nonprofit health service plan shall file with the Commissioner a complete statement of its financial condition, transactions, and affairs for the immediately preceding calendar year.

(2) The annual statement shall **[**contain the information required by the Commissioner and be certified by an independent certified public accountant**]:**

(I) BE IN THE FORM AND HAVE THE CONTENT APPROVED FOR CURRENT USE BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS OR ITS SUCCESSOR ORGANIZATION; AND

(II) CONTAIN ANY ADDITIONAL INFORMATION THAT THE COMMISSIONER REQUIRES.

(3) The applicable fee required by § 2–112 of this article shall be submitted at the same time as the statement.

(4) Unless the Commissioner extends the time for filing, a nonprofit health service plan that fails to file an annual statement on or before March 10 shall pay a penalty of:

(i) $100 for each day from March 1 to March 10, both inclusive; and

(ii) $150 for each day from March 11 to the day before the Commissioner receives the statement, both inclusive.

(b) At any time, the Commissioner may require a nonprofit health service plan doing business in the State to file an interim statement containing the information that the Commissioner considers necessary.

[(c) (1) (i) This paragraph does not apply to:

1. a health maintenance organization required to file an annual report under § 19–717 of the Health – General Article; or

2. an authorized insurer required to file an annual report under § 4–116 of this article.

(ii) On or before June 30 of each year, unless the Commissioner extends the time for good cause, each nonprofit health service plan shall file with the Commissioner an audited financial report for each affiliate and subsidiary owned by or under the control of the nonprofit health service plan during the immediately preceding calendar year.

(2) The report shall contain the information required by the Commissioner and be certified by an independent certified public accountant as to the financial condition, transactions, and affairs of each affiliate and subsidiary for the immediately preceding calendar year.

(3) Unless the Commissioner extends the time for filing, a nonprofit health service plan that fails to file an audited financial report on or before July 10 shall pay a penalty of:

(i) $100 for each day from June 30 to July 10, both inclusive; and

(ii) $150 for each day from July 11 to the day before the Commissioner receives the report, both inclusive.**]**

(C) (1) (I) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, ON OR BEFORE JUNE 1 OF EACH YEAR, A NONPROFIT HEALTH SERVICE PLAN SHALL FILE WITH THE COMMISSIONER AN AUDITED FINANCIAL REPORT FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(II) THE NONPROFIT HEALTH SERVICE PLAN SHALL HAVE THE AUDITED FINANCIAL REPORT PREPARED BY AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

(III) THE COMMISSIONER MAY:

1. SET REQUIREMENTS FOR THE FORM AND CONTENT OF THE AUDITED FINANCIAL REPORT; AND

2. FOR GOOD CAUSE, EXTEND THE TIME FOR FILING THE AUDITED FINANCIAL REPORT.

(2) WITH 90 DAYS' ADVANCE NOTICE, THE COMMISSIONER MAY REQUIRE A NONPROFIT HEALTH SERVICE PLAN TO FILE AN AUDITED FINANCIAL REPORT EARLIER THAN THE DATE SPECIFIED IN PARAGRAPH (1) OF THIS SUBSECTION.

(3) (I) THIS PARAGRAPH DOES NOT APPLY TO:

1. A HEALTH MAINTENANCE ORGANIZATION REQUIRED TO FILE AN ANNUAL REPORT UNDER § 19–717 OF THE HEALTH – GENERAL ARTICLE; OR

2. AN AUTHORIZED INSURER REQUIRED TO FILE AN ANNUAL REPORT UNDER § 4–116 OF THIS ARTICLE.

(II) ON OR BEFORE JUNE 1 OF EACH YEAR, A NONPROFIT HEALTH SERVICE PLAN SHALL FILE WITH THE COMMISSIONER AN AUDITED FINANCIAL REPORT FOR EACH AFFILIATE AND SUBSIDIARY OWNED BY OR UNDER THE CONTROL OF THE NONPROFIT HEALTH SERVICE PLAN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(III) THE COMMISSIONER MAY, FOR GOOD CAUSE, EXTEND THE TIME FOR FILING THE AUDITED FINANCIAL REPORTS.

(IV) THE AUDITED FINANCIAL REPORTS:

1. SHALL CONTAIN THE INFORMATION REQUIRED BY THE COMMISSIONER; AND

2. BE CERTIFIED BY AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT AS TO THE FINANCIAL CONDITION, TRANSACTIONS, AND AFFAIRS OF EACH AFFILIATE AND SUBSIDIARY FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(d) As part of the audited financial **[**report**]** **REPORTS** required under subsection **[**(c)**]** **(C)(3)** of this section, each nonprofit health service plan shall:

(1) file a consolidated financial statement that:

(i) covers the nonprofit health service plan and each of its affiliates and subsidiaries; and

(ii) consists of the financial statements of the nonprofit health service plan and each of its affiliates and subsidiaries, certified by an independent certified public accountant as to the financial condition, transactions, and affairs of the plan and its affiliates and subsidiaries for the immediately preceding calendar year;

(2) provide a list of:

(i) the names and addresses of and biographical information about the members of the board of directors of the nonprofit health service plan;

(ii) the total compensation, including all cash and deferred compensation in addition to salary, of:

1. each member of the board of directors of the nonprofit health service plan;

2. each officer of the nonprofit health service plan or any affiliate or subsidiary of the plan; and

3. any employee of the nonprofit health service plan or any affiliate or subsidiary of the plan designated by the Commissioner; and

(3) provide any other information or documents necessary for the Commissioner to ensure compliance with this subtitle.

(E) UNLESS THE COMMISSIONER EXTENDS THE TIME FOR FILING, A NONPROFIT HEALTH SERVICE PLAN THAT FAILS TO FILE AN AUDITED FINANCIAL REPORT ON OR BEFORE JUNE 10 SHALL PAY A PENALTY OF:

(1) $100 FOR EACH DAY FROM JUNE 1 TO JUNE 10, BOTH INCLUSIVE; AND

(2) $150 FOR EACH DAY FROM JUNE 11 TO THE DAY BEFORE THE COMMISSIONER RECEIVES THE REPORT, BOTH INCLUSIVE.

[(e)**] (F)** The statements and reports required under this section shall be in the form required by the Commissioner.

[(f)**] (G)** Whenever a corporation authorized under this subtitle makes a change that would result in a change in any of the information required under subsection (d) of this section, the corporation shall notify the Commissioner within 30 days after the change becomes effective.

14–413.

(a) On or before **[**April 1**] MARCH 1** of each year, each dental plan organization shall file with the Commissioner a **[**report, on the form that the Commissioner provides, that covers the activities of the dental plan organization for the**] COMPLETE STATEMENT OF ITS FINANCIAL CONDITION, TRANSACTIONS, AND AFFAIRS FOR THE IMMEDIATELY** preceding calendar year.

[(b) The report required under subsection (a) of this section shall include:

(1) a financial statement of the dental plan organization, including its balance sheet, receipts, and disbursements for the preceding year certified by a certified public accountant;

(2) any significant modification of information submitted with the application for a certificate of authority;

(3) the number of individuals who became enrollees during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(4) a description of the enrollee complaint system, including:

(i) the procedures of the complaint system;

(ii) the number of written complaints handled through the complaint system;

(iii) a summary of causes underlying the complaints; and

(iv) the current number, amount, and disposition of malpractice claims settled during the year by the dental plan organization and any of the dentists used by it; and

(5) any other information about the performance of the dental plan organization that the Commissioner requires.**]**

(B) THE ANNUAL STATEMENT SHALL:

(1) BE IN THE FORM AND HAVE THE CONTENT APPROVED FOR CURRENT USE BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS OR ITS SUCCESSOR ORGANIZATION; AND

(2) CONTAIN ANY ADDITIONAL INFORMATION THAT THE COMMISSIONER REQUIRES.

(C) UNLESS THE COMMISSIONER EXTENDS THE TIME FOR FILING, A DENTAL PLAN ORGANIZATION THAT FAILS TO FILE AN ANNUAL STATEMENT ON OR BEFORE MARCH 10 SHALL PAY A PENALTY OF:

(1) $100 FOR EACH DAY FROM MARCH 1 TO MARCH 10, BOTH INCLUSIVE; AND

(2) $150 FOR EACH DAY FROM MARCH 11 TO THE DAY BEFORE THE COMMISSIONER RECEIVES THE REPORT, BOTH INCLUSIVE.

(D) AT ANY TIME, THE COMMISSIONER MAY REQUIRE A DENTAL PLAN ORGANIZATION DOING BUSINESS IN THE STATE TO FILE AN INTERIM STATEMENT CONTAINING THE INFORMATION THAT THE COMMISSIONER CONSIDERS NECESSARY.

(E) (1) EXCEPT AS PROVIDED IN PARAGRAPH (5) OF THIS SUBSECTION, ON OR BEFORE JUNE 1 OF EACH YEAR, EACH DENTAL PLAN ORGANIZATION SHALL FILE WITH THE COMMISSIONER AN AUDITED FINANCIAL REPORT FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(2) THE DENTAL PLAN ORGANIZATION SHALL HAVE THE AUDITED FINANCIAL REPORT PREPARED BY AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

(3) THE COMMISSIONER MAY:

(I) SET REQUIREMENTS FOR THE FORM AND CONTENT OF THE AUDITED FINANCIAL REPORT; AND

(II) FOR GOOD CAUSE, EXTEND THE TIME FOR FILING THE AUDITED FINANCIAL REPORT.

(4) UNLESS THE COMMISSIONER EXTENDS THE TIME FOR FILING, A DENTAL PLAN ORGANIZATION THAT FAILS TO FILE AN AUDITED FINANCIAL REPORT ON OR BEFORE JUNE 10 SHALL PAY A PENALTY OF:

(I) $100 FOR EACH DAY FROM JUNE 1 TO JUNE 10, BOTH INCLUSIVE; AND

(II) $150 FOR EACH DAY FROM JUNE 11 TO THE DAY BEFORE THE COMMISSIONER RECEIVES THE REPORT, BOTH INCLUSIVE.

(5) WITH 90 DAYS' ADVANCE NOTICE, THE COMMISSIONER MAY REQUIRE A DENTAL PLAN ORGANIZATION TO FILE AN AUDITED FINANCIAL REPORT EARLIER THAN THE DATE SPECIFIED IN PARAGRAPH (1) OF THIS SUBSECTION.

15–605.

(f) (1) (i) On or before March 1 of each year, unless, for good cause shown, the Commissioner extends the time for a reasonable period, each managed care organization shall file with the Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.

(ii) At any time, the Commissioner may require a managed care organization to file an interim statement containing the information that the Commissioner considers necessary.

(iii) The annual and interim reports shall be filed in a form required by the Commissioner.

(2) (i) **[**On**] EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION ON** or before June 1 of each year, each managed care organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(ii) The audited financial report shall:

1. be filed in a form required by the Commissioner; and

2. be certified by an audit of an independent certified public accountant.

(3) WITH 90 DAYS' ADVANCE NOTICE, THE COMMISSIONER MAY REQUIRE A MANAGED CARE ORGANIZATION TO FILE AN AUDITED FINANCIAL REPORT EARLIER THAN THE DATE SPECIFIED IN PARAGRAPH (2) OF THIS SUBSECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010.

Approved by the Governor, April 13, 2010.