Homeowner's Insurance - Anti-Concurrent Causation Clause - Notice and Study

Pursuant to:
HB 695/Ch. 383, Sec. 2, 2013
Senate Finance Committee
Maryland General Assembly
Senate Finance Committee
2013 Interim
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The Senate of Maryland
Finance Committee
December 17, 2013

The Honorable Thomas V. Mike Miller Jr., Co-chairman
The Honorable Michael E. Busch, Co-chairman
Members of the Legislative Policy Committee

Ladies and Gentlemen:

The Senate Finance Committee respectively submits its report summarizing the committee's activities during the 2013 interim. The full committee held three meetings in Annapolis (June 6, November 12, and November 26). The June 6 and November 12 meetings were joint with the Senate Budget and Taxation Committee and the House Economic Matters Committee, respectively. November 26 was a full-day retreat. The Health Subcommittee and Transportation Subcommittee did not meet.

Members of the committee may have participated in other committees, commissions, and task forces, including the Workers' Compensation Benefit and Insurance Oversight Committee, the Joint Committee on Welfare Reform, the Joint Audit Committee, the Joint Committee on Unemployment Insurance Oversight, the Joint Committee on Health Care Delivery and Financing, the Joint Committee on Mental Health Services, the Maryland Health Care Reform Coordinating Council, the Joint Committee on Fair Practices and State Personnel Oversight, the Joint Committee on Information Technology and Biotechnology, the Task Force to Study Maryland Insurance of Last Resort Programs, the Task Force to Study the Applicability of the Maryland Prevailing Wage Law, and the Task Force to Study Economic Development and Apprenticeship. The activities of these committees are summarized separately from this report.

The committee expresses its appreciation for the advice and assistance provided by governmental officials, State agency staff, and members of the public during the 2013 interim. The committee looks forward to the same spirit of cooperation and assistance during the forthcoming 2014 session.

Respectfully submitted,

Thomas M. Middleton, Chairman
Senate Finance Committee

TMM/TDB/nes

cc: Mr. Karl S. Aro
     Mr. Warren G. Deschenaux
     Ms. Lynne B. Porter
Briefing on Recent Health Services Cost Review Commission Actions

On June 6, the committee held a joint briefing with the Senate Budget and Taxation Committee on the Health Services Cost Review Commission (HSCRC) and related actions on hospital rates. The committees heard from representatives from HSCRC and a panel of representatives from Maryland hospitals organized by the Maryland Hospital Association (MHA). The focus of the meeting was HSCRC’s most recent annual hospital rate adjustment, which is an annual exercise that updates the rates that hospitals may charge payers (Medicare, Medicaid, and insurers) for services provided by hospitals under the State’s all-payor system.

Normally, HSCRC’s annual rate adjustment does not attract legislative scrutiny, but the State is in the midst of applying for a new Medicare waiver from the federal government to alter the all-payor system. Currently, rates are set based on a fee-for-service basis, and HSCRC has proposed to set rates on a capitated basis, or more similar to a managed care framework. As a result of the pending approval of the waiver request by the federal government, the June rate update factor will only be for six months. It is the hope of HSCRC that by January 2014, they will know whether they are operating under the current rate-setting system, or under a new waiver.

During the briefing, HSCRC described the justification for the rate adjustments, which took effect on June 1. A number of factors were considered for the adjustment including inflation, the federal sequester, the financial condition of the industry, the waiver cushion (the rate at which the growth of hospital expenditures in Maryland was below the national average), and other miscellaneous factors. The hospital industry was engaged in the process to develop the rate adjustment. The June 1 rate adjustment was ultimately supported by MHA, but the MHA panel reiterated that developing the adjustment was not a smooth process. MHA had to urge HSCRC to look further into hospital profitability, the financial condition of the hospitals, and the effects of the sequester.

The initial State submittal of a new Medicare waiver is a work in progress, and HSCRC stated that they would continue to work with the hospitals, the State Medicaid program, and insurers, on the details as the final new waiver is adopted by the federal government.

The committees insisted that the development of a new waiver be a collaborative process with the various stakeholders.
On November 12, the committee held a joint meeting with the House Economic Matters Committee. Under Chapter 383 of 2013, the two committees were required to study the handling by insurers and the National Flood Insurance Program (NFIP) of property insurance claims in cases where there are two or more factors that could affect or cause the loss. As part of the study, the committees were required to review (1) the history, nature, scope, and general effect of the ACC clause; (2) the number of states that allow or do not allow the use of an ACC clause and the rationale given by states for allowing or disallowing use of an ACC clause; (3) the number of complaints involving the ACC clause filed with the Maryland Insurance Administration (MIA) in each of the past three years and their resolution; (4) the interaction between the use of the ACC clause by the insurance industry and the claims practices of NFIP; (5) the impact of disallowing the ACC clause in Maryland, including the impact on premium levels, underwriting practices, and competition; (6) the cost, fairness, and effectiveness of mediation processes, including the processes set up in the wake of Tropical Storm Sandy, and the likelihood that mediation could lead to regulatory action or class action and bad faith claims; and (7) the adequacy of the statutory notice informing insureds about exclusions and the ACC clause and whether the notice should (i) provide an explanation of how the ACC clause may be applied; or (ii) state that, if the insured would like an explanation of how the ACC clause may be applied, the insured should communicate with the insurer or with the insurance producer, if the insurer has provided the information to the insurance producer.

Starting January 1, 2014, Chapter 383 requires an insurer issuing a policy of homeowner’s insurance in the State that contains an ACC clause to provide the policyholder each year with a notice that (1) is clear and specific; (2) describes the ACC clause; (3) advises the insured to read the policy for complete information on the exclusions; and (4) states that the insured should communicate with the insurance producer or the insurer for additional information regarding the scope of the exclusions.

The committee heard from the following individuals on the industry’s perspective, including the history of the use and application of ACC clauses: Mr. Paul Tetrault, Policy Affairs Counsel, National Association of Mutual Insurance Commissioners (NAMIC); Mr. Eric Goldberg, Vice President, American Insurance Association (AIA); and Mr. Oyango A. Snell, State Government Relations Counsel, Property Casualty Insurers Association of America (PCI).

- When two or more events are simultaneously present when there is a loss to property, determining which event caused the loss may be a difficult task. ACC clauses generally provide that a loss is excluded from coverage if the loss arises from a combination of covered and noncovered perils. The language contained in a typical ACC clause does not function to refuse payment for an insured loss; conversely, the language functions to make sure that damage caused by an excluded peril is effectively excluded. ACC provisions allow insurers to clarify coverage that is based on premiums paid.
• The use of ACC clauses began in the 1980s in an effort by insurers to address uncertainty and inconsistent court rulings. For decades, courts struggled with the determination of whether coverage exists when excluded and covered perils interact to cause a loss. Courts attempted to address this issue by first applying the “efficient proximate cause doctrine” and then applying the “concurrent causation doctrine” imported from tort jurisprudence. As courts in some prominent jurisdictions began to require coverage using tort causation principles in construing policies that had been developed using narrower contract causation principles, insurers developed ACC clauses to clarify how a loss would be treated in a concurrent causation scenario in a manner consistent with the premiums paid for the coverage offered. ACC clauses do not “interact” with the claims practices of NFIP.

• The application of ACC clauses commonly arises in situations involving hurricane damage, where losses may be caused by both wind and water. The wind damage is usually covered by a homeowner’s insurance policy, but the damage caused by flood or rising water is typically excluded from coverage under the same policy. Most states allow ACC clauses in homeowner’s insurance policies. California and North Dakota are the only two states that have statutorily invalidated ACC clauses. Washington and West Virginia prohibit ACC clauses by adverse judicial decisions. When North Dakota invalidated ACC clauses in 2003, the number of claims per insured homes paid and the overall loss costs increased significantly. Insured costs are typically passed on to policyholders. Further, the number of insurers offering homeowner’s coverage in those jurisdictions declined. A study conducted in response to legislation in New York found that without ACC clauses, the state’s residents would pay higher premiums, mostly in areas susceptible to storm surge and flooding.

• In addition to water damage exclusion provisions, a change in policy to ban ACC clauses would abrogate other provisions of an insurance policy which are either uninsurable under any circumstance or insurable under separately purchased coverage, such as perils for pollution, dishonest acts by the insured, wear and tear, war, electrical interruption, nuclear damage, earthquake, and failure to protect the property at time of loss. Insurers price their policies with the expectation that they will not pay for damage from a covered peril in combination with a noncovered peril. If ACC clauses were banned, an insurer would have to manage the increased exposure by increasing premiums; purchasing additional reinsurance, and passing the costs on to policyholders; increasing deductibles, shifting more risk to the policyholders; or not renewing existing policies or writing less new business. To address these issues, consumers need to be educated about the limitations in coverage by disclosure and the need for additional coverage to fill any gaps, for example, flood coverage. Damage from water from the ground up (flood) is not covered; however, damage from wind along with water and damage from water used to put out a fire are covered. If an earthquake causes a fire and the fire burns the house, the fire damage is covered, though other earthquake-related damage is not.
Post-catastrophe mediation programs benefit both consumers and insurers in that they are a quick, impartial way to dispute and reach settlement through a neutral third party. Maryland should adopt a regulation similar to the mediation program that New Jersey adopted by regulation.

From MIA, the committees heard from the following individuals on the regulator’s perspective, including complaints from policyholders: Ms. Tinna Quigley, Director of Government Relations and Ms. Sandra Castagna, Associate Commissioner for Property and Casualty.

Until the 1960s, property insurance policies generally were limited to only one named peril: fire. Fire insurance policies were gradually expanded to include damage from other named perils, including lightning, windstorm, hail, explosion, riot, civil commotion, aircraft, vehicles, smoke, vandalism, malicious mischief, and breakage of glass. Only named perils were covered; all others were excluded. Starting in the early 1970s, insurers began changing to “all risks” policies that would cover all causes of loss, unless specifically excluded under gradually lengthening lists of excluded perils. Simultaneously, the burden of proof of coverage shifted from the insured to the insurer to prove that the cause of loss is an excluded peril. During that time, courts held that when covered risk and excluded risk constitute “concurrent proximate causes” of an accident, the insurer is liable so long as one of the causes is covered by the policy. Courts also held that, in determining whether a loss is within an exception in a policy, where there is a concurrence of different causes, the “efficient proximate cause” – the one that sets others in motion – is the cause to which the loss is to be attributed, though the other causes may follow it, and operate more immediately in producing the disaster; this doctrine determination shifts the burden to the insured to show a named peril is the “efficient proximate cause,” the primary cause of loss. The purpose of ACC clauses is to combat the misapplication of the concurrent causation doctrine from tort law to first-party property claims.

The Insurance Services Office, Inc, (ISO) introduced the ACC clause in its 1990 edition of the homeowner’s insurance policy. Twenty years later, the 2010 edition reads: “We do not insure for loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss. These exclusions apply whether or not the loss event results in widespread damage or affects a substantial area.” ACC clauses are now standard in nearly all Maryland property insurance policies.

Reviewing the national situation, Maryland and 20 other states follow the “efficient proximate cause” doctrine but allow insurers to use ACC clauses to override the doctrine. Sixteen other states follow the “efficient proximate cause” doctrine but it is unknown whether they allow insurers to use ACC clauses. Three states reject the “efficient proximate cause” doctrine outright and allow insurers to use ACC clauses. Four other states reject the “efficient proximate cause” doctrine and prohibit insurers from using
ACC clauses. Four states follow the “efficient proximate cause” doctrine and prohibit insurers from using ACC clauses, two by statute and two by case law. It is not clear how the remaining two states handle ACC clauses.

- MIA reviewed complaints based on NAIC’s standard data codes, including fire/allied lines and homeowners. In 2012, there were 696 complaints for all property insurance-related claims, an increase of 139% from 2010. In 2012, there were 453 complaints through MIA’s Rapid Response Program, an increase of 71% from 2010. Forty-five of the complaints for all property insurance-related claims involved the application of the ACC clauses while 21 of the Rapid Response Program complaints involved the application of the ACC clauses. In 40 of the 45 all property insurance-related complaints, MIA upheld the insurers’ determinations; in the remaining five complaints, the insurer reversed its position during the investigation and provided coverage.

- Maryland law does not require insurers to file disclosure notices or MIA to review and approve the notices. MIA issued a bulletin in order to obtain notices. In reviewing the notices, MIA observed that (1) some insurers quote the policy language directly which does little to explain anything to the policyholders; (2) some insurers itemize the exclusions contained in the basic policy which may be confusing to insureds who have purchased additional coverage by endorsement; (3) some insurers’ notices do not appear to be clear and specific and could be considered misleading; and (4) a few insurers provide an example to policyholders, making the notices appear more helpful.

- MIA prepared a comprehensive chart that provides information relating to mediation processes across the county. At least 12 states have post-disaster mediation regulations.

The committees heard from Mr. Donald Waters, Insurance Examiner, Claims and Appeals Branch, DHS/FEMA, on the handling of claims under NFIP when two or more factors affect or cause the loss.

- NFIP only handles flood claims. In New Jersey, from Tropical Storm Sandy, there was no coverage issue of wind versus flood. After determining the water line, FEMA covers the flood damage that is below the line and the homeowner’s insurance policy covers the wind damage that is above the line. Typically, this is easily distinguishable.

The People’s Insurance Counsel, Mr. Peter K. Killough, submitted a letter indicating that “ACC clauses are profoundly anti-consumer and lead to egregiously bad results for policyholders.” The letter states that “...insurers have increasingly relied upon ACC clauses contained in policies, which means that if a loss is caused by two or more perils, one that is covered by insurance and one that is excluded, then the entire loss is excluded, regardless of which peril is the primary cause or whether the perils occurred concurrently or in a sequence.” The letter summarizes several examples.
The committees expressed concern that, depending on the situation, insurers may not pay for damages from a covered peril when a noncovered peril also causes damage. They also expressed concern that premiums could increase if a ban on the ACC clause were adopted. Another concern to the committees is the impact of the federal Biggert-Waters Flood Insurance Reform Act of 2012 and NFIP's recent implementation of that Act, which is intended to raise rates on policyholders whose premiums have historically been heavily subsidized and have not reflected the true risk to their property.

Committee Discussion of the Attorney General's Opinion on the Status of University of Maryland Medical System and the University of Maryland Medical Center

During the 2013 session, the committee considered Senate Bill 759, State Personnel – Equality for Maryland Caregivers Act of 2013. The bill would have added the University of Maryland Medical Center (UMMC) to the list of employers covered under the State collective bargaining law. There was no action taken on the bill and instead the committee requested an Attorney General's opinion on the status of the University of Maryland Medical System (UMMS)/UMMC in relation to State government. In addition, the committee requested that the opinion of the Attorney General include an assessment of the status of the UMMC employees as to whether they may fall under the jurisdiction of the National Labor Relations Board (NLRB) or whether they may be subject to various State labor laws, including the laws providing for collective bargaining for State employees.

On November 21, the Attorney General issued his opinion. On November 26, the committee heard from Mr. David Smulski, staff to the committee, who summarized the Attorney General's opinion. Basically, the Attorney General opined that:

- UMMC is exempt from the requirements of the federal National Labor Relations Act and, therefore, probably does not fall under the jurisdiction of NLRB. Only NLRB can actually make such a determination, but in the past NLRB has ruled similarly;

- UMMC employees are not covered by the State collective bargaining law; and

- the General Assembly has the power and ability to grant UMMC employees collective bargaining rights under State law because there is enough nexus between State government and UMMS, as detailed in the opinion.

The committee then discussed the merits of the opinion and the individual points of view of the members were expressed regarding the independence of UMMS from State government.
The committee deferred any further action or decision on the matter until the 2014 session, when legislation is again expected to be introduced that would grant collective bargaining rights to UMMC employees.

Update on the Prescription Drug Monitoring Program

Data collected by the Department of Health and Mental Hygiene (DHMH) has indicated that drug poisoning kills more Maryland residents than auto accidents, and that prescribed opioids are a major contributor to the problem. In addition, the use of heroin is spiking due to the high cost of prescription opioids. In response, legislation was enacted in 2011 that established the Prescription Drug Monitoring Program (PDMP). On November 26, the committee continued with its updates on PDMP, and heard from Ms. Laura Herrera, MD, MPH, Deputy Secretary for Public Health Services, DHMH, and Mr. Michael Baier, PDMP Coordinator, Alcohol and Drug Abuse Administration, DHMH.

The purpose of PDMP is to reverse prescription drug abuse by constructing a database to track prescription drug use in Maryland. Unfortunately, PDMP is reactive in that it only tracks the prescribing and use of prescription drugs and cannot be used to anticipate trends or future actions. For example, PDMP law does not allow DHMH to analyze the data and law enforcement agencies have to seek out the data. There are no projections yet on how PDMP will reduce drug abuse, although other states are just starting to collect data. DHMH anticipates that within the next six months outcome data may be available. It will be possible to track PDMP data to specific areas, such as census tract data, and in fact three jurisdictions have already established programs that could use the data.

During the briefing, committee members asked questions regarding the disposal of controlled substances. The federal Drug Enforcement Agency has a program and works with local law enforcement agencies to give residents the ability to “drop off” unused prescription drugs at least twice a year. Some local law enforcement agencies also have supervised drop off sites. Pharmacies are prohibited by law from accepting unused prescription drugs. DHMH also stated that workers compensation insurance providers could require in a contract that PDMP be checked by providers, but it is not required by law.

To initiate funding and implementation for PDMP, federal grants were obtained from the Governor’s Office of Crime Control and Prevention; it is now anticipated that the ongoing operations of PDMP will be funded through the general fund.

Update on the Medicare Waiver

As a follow-up to the June briefing with the Budget and Taxation Committee, as well as briefings during the 2013 session, on November 26, the committee continued with its series of updates on the Medicare waiver. On November 26, the committee heard from
Dr. Joshua Sharfstein, Secretary, DHMH and Mr. John Colmers, Chairman, HSCRC. In addition, Ms. Carmela Coyle, President, MHA made a presentation to the committee.

The update covered the period from the previous committee update in April, close to the end of the 2013 session. Since last April, a revised application has been submitted to the federal Centers for Medicare and Medicaid Services (CMS) and consists largely of the same basic idea, capitated payments for hospitals, but the details have changed. Instead of focusing on the cost per admission and the effect a case has on total hospital costs, a global budget for each hospital will be determined. Any reduction in hospital admission costs will allow the hospital to keep the difference between actual admissions costs and its global budget. Growth rates (inflation) will be factored into the rate-setting system, and will be based on the general growth of the economy, not just one health care inflation indicator.

Under the current all-payer system, hospitals can be squeezed by fee-for-service payments. Mr. Colmers stressed that there has to be a change, and the status quo is not sustainable. “The new system will allow innovation for hospitals to do things differently.” The State can ask CMS for an adjustment to Medicare payments (the most significant payor in the rate-setting system) if inflation increases beyond the rate of growth. Global budgets have been instituted in the smaller community hospitals where capacity has been decreasing. So far, no urban hospital has been subjected to global budgeting. Under existing law, HSCRC has the broad authority to implement the new system, but it cannot be accomplished alone. HSCRC will have to continue to work with DHMH, MHA, and insurers to successfully implement the new Medicare waiver. The Secretary and Mr. Colmers remain confident CMS will approve the new waiver and that they will be able to implement the new waiver on January 1, 2014.

MHA stated that they are satisfied with the current state of the waiver request. Challenges remain, however, because they believe the State is “learning by doing.” For example, limits under global budgeting are very tight, and the rate of growth is also very limited. In addition, there should be alignment with physician incentives to accommodate global budgeting, and technology also has to improve. Most hospitals are pulling 15% to 20% out of their base budgets to meet new goals under the new waiver. Finally, MHA hopes that the State will revisit and eliminate the Medicaid assessment on hospital payments, which was implemented to balance the State budget, because the assessment will make it increasingly difficult to meet the new waiver requirements.

The committee will continue to monitor the status of the new Medicare waiver and its effect on the hospital all-payer rate-setting system through the 2014 session.

Update on Health Reform Implementation

On November 26, the committee received an update on the implementation of health care reform in the State from Dr. Joshua Sharfstein, Secretary, DHMH, and Ms. Carolyn Quattrocki, Executive Director of the Governor’s Office of Health Care Reform.
Maryland Health Connection Launch

Maryland Health Connection (MHC), the State-established marketplace for offering qualified health plans (QHPs) under the federal Patient Protection and Affordable Care Act (ACA), launched on October 1, 2013, and is offering 45 QHPs from eight health insurance carriers. The QHPs span a spectrum of “metal” levels – designations that correspond to plan actuarial values – with 11 at a bronze level (60%), 16 at a silver level (70%), 12 at a gold level (80%), and 3 at a platinum level (90%). There are also three catastrophic QHPs offered on MHC. Secretary Sharfstein reported that individual rates for QHPs offered on MHC are among the lowest nationwide when compared with QHPs offered on other state exchanges.

Enrollment Data

The State’s original goal for enrollment was to sign up 150,000 individuals in QHPs by early March 2014. As of November 22, however, only 2,253 individuals had enrolled in QHPs. Regarding Medicaid enrollments, 9,609 individuals have been determined eligible for coverage, and this is in addition to the approximately 84,000 individuals who are currently enrolled in the State’s Primary Adult Care program and will automatically receive full Medicaid benefits beginning in January 2014. Including the 84,000 automatic Medicaid enrollments, the State now expects that 90,000 individuals will gain new coverage beginning in January 2014.

Website Problems and Next Steps

MHC’s website has experienced a number of problems, such as users being unable to establish accounts and encountering error messages when attempting to access pages on the site. Maryland Health Benefit Exchange’s (MHBE) prime contractor tasked to develop the website is bringing in new resources and expertise to improve the website’s performance. These efforts are focused on three key goals: (1) improving the user experience (e.g., making the website faster, reducing error messages, and improving reliability); (2) assuring the accuracy of eligibility determinations; and (3) transmitting secure files of enrollment data to carriers and Medicaid.

MHBE is delaying the launch of the SHOP exchange, the health insurance marketplace for small employers, from January 1, 2014, to April 1, 2014, to allow staff to focus efforts on improving performance of the individual exchange. In an effort to simplify design features of MHC’s website, MHBE is assigning to health insurance carriers the responsibility to bill for the purchase of QHPs and is maintaining the provider search function on another website maintained by the Chesapeake Regional Information System for our Patients (CRISP). The federal government has extended the enrollment deadline to December 23, 2013, for coverage that will be effective on January 1, 2014. The payment deadline has also been extended to January 15, 2014, for coverage that will be effective retroactively on January 1, 2014.
Cancellation Letters and Early Renewals

Approximately 73,000 individuals in the State received letters from their health insurance carrier indicating that their plans were being cancelled due to requirements of the ACA that go into effect on January 1, 2014. The Insurance Commissioner issued a bulletin in November authorizing carriers to extend an option to individuals to renew their plans early. Two carriers, CareFirst and Kaiser, are offering early renewals that would extend coverage through December 2014. It is estimated that the early renewal option offered by these carriers will be available to approximately 55,000 of the individuals who received cancellation letters.

MHIP and Potential Legislation in 2014

Under Chapter 159 of 2013, the Maryland Health Insurance Plan (MHIP) Board must determine the appropriate timing for closure of MHIP plans for current enrollees. The MHIP Board has extended plans for MHIP+ members from December 31, 2013, through March 31, 2014. MHIP+ is the optional State premium subsidy program for low- or moderate-income individuals. Current MHIP plans are up for renewal in July 2014 and MHIP will determine whether these plans will close or renew for another year in March 2014. The Hilltop Institute is analyzing the potential impact on health insurance plan affordability in the individual exchange if MHIP surplus funds are used to establish a State reinsurance wrap-around program or a direct subsidy program. If the analysis indicates that a greater impact on affordability may be achieved through a direct subsidy program, statutory authorization may be needed to use MHIP funds in this manner. Legislation may also be needed to establish a Community Integrated Medical Home initiative.

Committee members expressed concern about the technical problems with MHC’s website and the low enrollment in QHPs and conveyed a need for reasonable assurances that the website would be fixed in a timely manner. In response to a question about Maryland’s performance when compared to other states, Secretary Sharfstein acknowledged that other state-established exchanges generally have experienced more success in enrolling individuals through their websites. The Secretary attributed this difference in performance to MHBE’s use of off-the-shelf software and other states designing websites with a narrower focus.

Update on the Integration of Behavioral Health Services

On November 26, the committee received an update on the integration of behavioral health services from Mr. Chuck Milligan, Deputy Director of Health Care Financing, DHMH, and Dr. Gayle Jordan-Randolph, Deputy Director of Behavioral Health and Disabilities, DHMH.
Development of the Behavioral Health Model

DHMH is currently in Phase III of a three-stage process to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues. A steering committee has recommended a performance-based carve-out model integrating mental health and substance use services under a single administrative services organization (ASO). In recent months, additional stakeholder meetings have been held to inform the model, addressing, among other subjects, the use of financial incentives and shared savings, care coordination, billing issues, managed care organization specifications, and quality reporting and measurement. DHMH plans to release the request for proposals for the ASO in early 2014, with the goal of implementing a new system in January 2015.

The goal of the behavioral health model is to provide a seamless service delivery system that protects consumers and the public while providing timely access to services, care coordination, and wellness and recovery for all individuals both covered by Medicaid and the uninsured. Performance-based incentives and penalties will be built into the ASO contract. There will also be provisions to resolve adverse selection; develop competent provider networks; promote information exchange; and establish multidisciplinary care coordination teams that would include ASO staff with mental health and substance use disorder experience and would coordinate with core service agencies, local addiction authorities, and MCOs.

Eligibility Policy for the Uninsured

Under the current eligibility policy for the uninsured, individuals with income under 200% of the federal poverty level (FPL) are generally eligible for treatment services. For individuals with income above 200% FPL, the Alcohol and Drug Abuse Administration applies a sliding fee schedule for treatment services whereas the Mental Health Administration does not. Under the new model, DHMH is proposing one standard policy for those accessing State-only services, with no sliding fee schedule for either mental health or substance use disorder (SUD) services. Services will be provided for up to three months based on medical necessity to uninsured individuals who have income under 250% FPL and meet other specified criteria. A single ASO will authorize all mental health and outpatient SUD services.

Authorization and Payment for SUD Services

Authorization and payment for Medicaid reimbursable SUD services will be handled by a single ASO. However, authorization and payment for non-Medicaid reimbursable services, such as residential services, will be handled by local addiction authorities.

Fiscal Impact of the Model and Changes to Rate Setting

Under the model, the ASO will continue to administer Medicaid specialty mental health services and will assume responsibility to administer Medicaid substance use services. The ASO will also continue to administer mental health services to the uninsured that are not covered
under Medicaid, as well as outpatient substance use services for uninsured individuals who are eligible for, but not enrolled in, Medicaid. DHMH estimates that adding substance use services under the ASO contract will amount to $2.3 million in added costs to the general fund. In addition, the carve-out of SUD services will result in $2.4 million in lost Rate Stabilization Fund monies from the premium tax on MCO revenue. These new costs and lost revenue will be offset, however, by a downward adjustment to rates paid to MCOs due to the carve-out of SUD services, resulting in $1.9 million in savings to the general fund. In total, the annual new costs and lost revenue to the general fund, after the MCO rate adjustment, from the new ASO contract will amount to $2.8 million. By improving quality of care and bending the cost curve, DHMH aims, however, to achieve a 1% reduction in inpatient services, which would save the department $1.6 million.

Integrating Local Authorities and Expanding Outcome Measures

Core service agencies (CSAs), responsible for planning, management, and other functions for the local mental health system, and local addiction agencies (LAAs), responsible for planning, management, and other functions for substance use services at the local level, are at various stages of integration. Approximately one-third of CSAs and LAAs have already merged. The new model will implement more robust and integrated data reporting that will allow the department to measure additional outcomes, such as the total cost of care from mental health and addictions services, as well as from somatic services, per member per month.

Motor Vehicle Insurance Compliance Program

On November 26, the committee heard from Ms. Christine Nizer, Deputy Administrator for Central Operations and Safety Programs for the Motor Vehicle Administration (MVA). Ms. Nizer provided the following information.

- Chapter 421 (House Bill 1180) of 2012, effective October 1, 2012, requires motor vehicle insurers to immediately notify MVA electronically of lapses, terminations, reinstatements, policy changes, and new business for vehicles registered in Maryland. MVA is notified every 30 days of additions, deletions, and/or modifications to fleet policies. MVA set up a website for insurers to transmit data daily.

- In addition to implementing the new law, MVA conducted a comprehensive review of systems and processes to identify additional improvements aimed at reducing the number of uninsured drivers. System improvements resulted in an increase of 29% in automated new business matches from fiscal 2011 to 2013. Further, case closures increased 40% during the same period in matches that identified cars that were not uninsured due to being salvaged or transferred out of State. MVA expanded the “eFR-19,” an electronic program, to include over 9,000 insurance agents, resulting in a decrease of 14% in manual reporting of insurance verification forms. The expansion allows new information to be received on cases that are referred to the Central Collection Unit.
Overall the improvements resulted in about 58% of new business and 65% of cancellations reported in 0 to 15 days in fiscal 2013, up from 46% and 52%, respectively, in fiscal 2011. Further, from fiscal 2011 to 2013, first notices to policyholders who were past due on premiums were reduced by over 13,000 and suspensions were reduced by over 11,000.

- Approximately 4.5% of the 4.8 million registered vehicles have insurance compliance issues. Future MVA enhancements include emailing owners that MVA has been notified that the owner’s insurance has been cancelled on a vehicle but that MVA has not been notified that the owner secured insurance from another insurer, working with law enforcement to streamline the flagging process, and interfacing with the destroyed vehicle file (National Motor Vehicle Titling Information System) to check for salvaged and junk vehicles.

In expressing concern that the rate of uninsured drivers as calculated by MVA is lower than what is reported by other organizations, the committee requested MVA to hone in on a methodology that may provide a more accurate rating.

Energy Issues

On November 26, the committee heard from Mr. Kevin Hughes, Chairman, Public Service Commission (PSC) and Ms. Abigail Hopper, Director, Maryland Energy Administration (MEA).

PSC Activities

Chairman Hughes provided the following information relating to the PSC activities.

Reliability – Utility Performance

PSC Rulemaking (RM) 43 specifies performance metrics that utilities have to adhere to for compliance with reliability standards, including outage frequency and duration limits, service restoration limits, timely downed wire response, timely customer telephone calls, and proactive tree trimming. Calendar 2013 was the first year that the RM 43 annual performance reports were filed and reviewed. Except for two utilities that are on remediation plans (Delmarva Power and Light (DPL) and Potomac Edison (PE)), all utilities complied with the standards, meaning no penalties were warranted.

By May 1, 2014, PSC will receive filings from PSC staff concerning ways to continue enhancing PSC’s oversight of electric service reliability, including draft regulations revising RM 43 standards (relating to major outage event data, objective standards for estimated times of restoration, and the poorest performing feeder standard). PSC received on November 18, 2013, the PSC staff’s report of the Derecho Vulnerable Individuals Workgroup. PSC staff will file an investigative report on January 1, 2014, based on PSC’s September 9, 2014 order, which directs
BGE to report on its reliability enhancement work plan to add feeders identified in Howard County's Petition.

**EmPower Maryland**

There has been continued improvement in reaching the EmPower goals, but more is needed. BGE is on track to reach 44% of its 2015 overall energy reduction goal, Pepco 51%, PE 65%, and DPL 81%. SMECO has gone beyond its goal (157%). For 2015 peak reduction goals, Pepco is on track to reach 34% of the goal, SMECO 48%, BGE 57%, and PE 186%. DPL has gone beyond its goal (257%). For the next three-year cycle of EmPower programs, PSC has approved almost $95 million, with more than half of the funds for commercial and industrial programs. PSC has issued a request for proposals (RFP) for baseline and potential studies for post-2015 planning of attaining future savings.

**Renewable Portfolio Standard (RPS)**

For calendar 2012, the RPS obligation for Tier 1 nonsolar was fully met with the retirement of renewable energy credits (RECs), meaning that no alternative compliance penalty (ACP) was assessed. For Tier 1 solar, the RPS obligation was not fully met, resulting in a $4,400 ACP assessment (a significant improvement from 2008 and 2009 when over $1 million of ACP assessments were imposed in each of those years). Also, for Tier 2, the RPS obligation was not fully met, resulting in a $1,050 ACP assessment. Since the inception of RPS in 2006, about 5,500 megawatts (MW) of capacity have been installed, mostly attributable to solar units located in Maryland.

The committee expressed concern that, while the subsidization of the development of renewable sources and the use of net metering is still at a low level, there needs to be discussion about the payment of fixed distribution costs. The committee requested that PSC notify the committee if PSC determines that the payment of fixed distribution costs are inadequate as a result of the growth in renewable sources and the use of net metering.

**Natural Gas Prices and Residential Electric Standard Offer Service (SOS) Rates**

Wholesale natural gas prices remain at historically low levels. The daily spot prices from 2005 to 2013 show the lowest rates in the third quarter of 2009, the second quarter of 2012, and the fourth quarter of 2013. Prices are anticipated to remain low due to fracturing efforts. PSC will recommend whether it is in the public interest for PSC to assist in safety inspections of interstate gas lines. Electric SOS prices have decreased recently, with the price hovering around $.08/kwh for the 2013 winter for BGE, Delmarva, and Pepco and around $.05/kwh for Potomac Edison. With 25% of the future SOS load secured every six months, the 2014 summer filings are showing a slight decline. Generally, residential customers will save about $150 to $200 in 2014 due to the lower prices.
Smart Meters

BGE installed almost 481,000 smart meters (35% of the total to be installed) with completion planned for the end of 2014. About 5.5% of customers have deferred installation (opted-out). PSC ordered BGE to increase efforts to reach nonresponsive customers, especially customers who have indoor meters. Pepco installed almost 551,000 smart meters (99% of total) with 0.4% deferred installation. DPL installed over 106,500 smart meters (92% of total) with 1.5% deferred installation. SMECO’s 150,000 smart meter plan was approved in June 2013. PE has not filed a smart meter plan. To opt-out of receiving a smart meter, customers must make a request in writing to PSc. PSC plans to decide at the end of 2013 regarding the costs that would be imposed on opt-out customers. Currently, there is no additional cost imposed on customers who keep an old meter. However, there is a cost impact for utilities to maintain two types of meters. While there is no compelling evidence that smart meters cause health problems, PSC understands that there is a belief that they do cause health problems.

Committee members expressed concern about whether the opt-out guidelines are clear to customers, and that PSC needs to do more education and outreach. Also, committee members expressed concern that smart meters have not been around long enough to know the actual health hazards.

Competitive Electricity Suppliers

As of July 2013, almost 524,500 residential (26%) and almost 103,000 nonresidential (42%) customers are being served by competitive electricity suppliers. There are 285 electricity suppliers and 199 brokers/aggregators licensed by PSC. PSC initiated an investigation into Starion Energy PA, Inc.’s marketing practices as a result of 196 complaints (alleged misrepresentation and/or fraud, very high rates, and slamming and billing disputes).

Other Major Commission Activities

There have been numerous recent filings at PSC, including BGE, Pepco, DPL, Washington Gas and Light (WGL), and Columbia Gas rate cases and BGE, Columbia Gas, and WGL cases for surcharges to accelerate gas infrastructure replacement projects (known as “STRIDE”). PSC issued an RFP for a consultant to assist in the development of the offshore wind regulations and project application. In 2013, PSC approved 1,835 solar facility certification applications, amounting to 40 MW of capacity. Participating utilities in the supplier diversity memorandum of understanding (MOU) exceeded the $311 million target in 2012. PSC is determining whether UberX and Lyft, both ridesharing services, are required to be licensed as a common carrier (for-hire) under current regulations. PSC will review the matter of allowing drivers of Baltimore City and Baltimore County taxicabs to collect the city’s new excise tax.

Committee members indicated that, while PSC is investigating whether ridesharing services falls under PSC common carrier regulations, the legislature should make the ultimate decision as to whether to expand the current for-hire licensing scheme to ridesharing services.
MEA Activities

Director Hopper provided the following information relating to MEA activities.

EmPower Maryland

The State is exceeding the peak demand goal with a 10.8% reduction to date (anticipated at 17.7% by 2015); this is equivalent to avoiding one coal power plant. However, the State is not meeting the consumption goal with a 9.4% reduction to date (anticipated at 9.7% by 2015). MEA focuses on commercial and industrial programs. The challenge is to implement building upgrades that achieve deep electricity savings of 20% or more. For those who participate, there are $4.5 million in grants available with awards ranging from $20,000 to $500,000.

Offshore Wind

Currently, several workgroups are meeting as required under Chapter 3 (House Bill 226) of 2013, including the Offshore Wind Business Development Fund Advisory Committee, the Technical Education Task Force, and the Clean Energy Program Task Force. The workgroups are considering models in other states.

A committee member expressed concern that the membership of the advisory committee does not include representatives of minority business enterprises that have the equity capacity to participate in offshore wind contracts. MEA agreed to revisit the membership and make appropriate changes.

Thermal Energy Task Force

Under Chapters 322 and 323 (Senate Bill 797/House Bill 1084) of 2013, the task force is required to study incorporating thermal energy sources into RPS. Thermal renewable energy systems are efficient and can replace inefficient electric systems used to heat buildings and water.

Regulated Sustainable Energy Contracts

Under Chapter 625 (House Bill 621) of 2013, MEA is authorized to conduct a feasibility study of using the Contract Lien Act to secure financing for residential energy projects, pilot a program based on the results of the feasibility study, and implement a program if the pilot is successful. MEA’s authorization is unique and could provide expanded access to affordable capital to residents who want to install energy projects.

Emergency Generator Task Force

Chapter 481 (Senate Bill 481) of 2013 created a task force to study implementing a sales tax holiday or tax credit for emergency preparedness supplies and/or backup generation.
Maryland Strategic Energy Investment Fund (SEIF) Formula

As originally set effective June 1, 2008 and starting with fiscal 2009, 17% of the funds were to be used to provide low-income energy bill payment assistance, 23% for residential rate relief, at least 46% for low and moderate income energy efficiency programs, up to 10.5% for renewable energy, energy education, and climate change programs (at MEA and the Maryland Department of Environment), and up to 3.5% (up to $4 million) for MEA administrative expenses. The legislature altered these percentages for fiscal 2010 and 2011 to be up to 50%, 23%, at least 17.5%, at least 6.5%, and up to 3% ($4 million cap), respectively and again altered these percentages for fiscal 2012 to 2014 to be up to 50%, 0%, at least 20%, at least 20%, and up to 10% ($4 million cap), respectively. For fiscal year 2015 and beyond, the percentage allocations revert back to fiscal 2009 levels.

The committee expressed interest in discussing the allocation of SEIF for fiscal 2015 and beyond.
Maryland General Assembly
House Economic Matters Committee

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December 13, 2013

The Honorable Thomas V. Mike Miller, Jr., Co-chairman
The Honorable Michael E. Busch, Co-chairman
Members of the Legislative Policy Committee

Ladies and Gentlemen:

On behalf of the House Economic Matters Committee, I am submitting a summary report of our activities during the 2013 legislative interim.

When the 2013 session ended, the members of the Economic Matters Committee anticipated studying a broad range of issues within its subject matter jurisdiction. In addition, the committee referred issues to various State agencies for further study and collaborative work. During the interim, the full committee went on a site visit to Baltimore, related to economic development, and Frederick, related to alcoholic beverages. The full committee also met once jointly with the Senate Finance Committee to study anti-concurrent causation (ACC) clauses in homeowner’s insurance policies.

Alcoholic Beverages

On October 17, 2013, the committee visited two breweries and a winery located in Frederick County. During the site visit, the members heard from holders of a Class 3 winery license, a Class 5 brewery license, and a Class 8 farm brewery license. The business owners provided varying perspectives on the regulatory climate in Maryland and offered both praise and suggestions for improvement of State alcoholic beverages policymaking. Specifically, the winery owner praised the General Assembly’s adoption of the wineries and vineyards income tax credit and positively compared his dealings with State regulators to his dealings with local zoning and health officials. In turn, the farm brewery license holder raised some practical concerns about the recently enacted refillable container laws.
Economic Development

On October 30, 2013, the committee visited the Port of Baltimore and the University of Maryland Baltimore (UMB) BioPark. While touring the Port, the members toured the Masonville Cove Environmental Education Center and received information from representatives of the Maryland Port Administration on the Port’s business performance and Dredged Material Management Program. The attendees also toured the Seagirt and Dundalk marine terminals and took a short cruise on the vessel MaryLynn to survey public and private pier and cargo facilities. At BioPark, the members received an overview of UMB and BioPark, discussed research commercialization efforts, and toured both the Maryland Proton Treatment Center and Paragon Bioservices.

Property and Casualty Insurance

On November 12, 2013, the committee jointly met with the Senate Finance Committee. Under Chapter 383 of the Acts of 2013, the two committees were required to study the handling by insurers and the National Flood Insurance Program (NFIP) of property insurance claims in cases where there are two or more factors that could affect or cause the loss. As part of the study, the committees were required to review: (1) the history, nature, scope, and general effect of the ACC clause; (2) the number of states that allow or do not allow the use of an ACC clause and the rationale given by states for allowing or disallowing use of an ACC clause; (3) the number of complaints involving the ACC clause filed with the Maryland Insurance Administration (MIA) in each of the past three years and their resolution; (4) the interaction between the use of the ACC clause by the insurance industry and the claims practices of the NFIP; (5) the impact of disallowing the ACC clause in Maryland, including the impact on premium levels, underwriting practices, and competition; (6) the cost, fairness, and effectiveness of mediation processes, including the processes set up in the wake of Tropical Storm Sandy, and the likelihood that mediation could lead to regulatory action or class action and bad faith claims; and (7) the adequacy of the statutory notice informing insureds about exclusions and the ACC clause and whether the notice should (i) provide an explanation of how the ACC clause may be applied or (ii) state that, if the insured would like an explanation of how the ACC clause may be applied, the insured should communicate with the insurer or with the insurance producer, if the insurer has provided the information to the insurance producer.

Starting January 1, 2014, Chapter 383 requires an insurer issuing a policy of homeowner’s insurance in the State that contains an ACC clause to provide the policyholder each year with a notice that: (1) is clear and specific; (2) describes the ACC clause; (3) advises the insured to read the policy for complete information on the exclusions; and (4) states that the insured should communicate with the insurance producer or the insurer for additional information regarding the scope of the exclusions.
The committee heard from the following individuals on the industry’s perspective, including the history of the use and application of ACC clauses: Mr. Paul Tetrault, Policy Affairs Counsel, National Association of Mutual Insurance Commissioners (NAMIC); Mr. Eric Goldberg, Vice President, American Insurance Association (AIA); and Mr. Oyango A. Snell, State Government Relations Counsel, Property Casualty Insurers Association of America (PCI).

- When two or more events are simultaneously present when there is a loss to property, determining which event caused the loss may be a difficult task. ACC clauses generally provide that a loss is excluded from coverage if the loss arises from a combination of covered and non-covered perils. The language contained in a typical ACC clause does not function to refuse payment for an insured loss; conversely, the language functions to make sure that damage caused by an excluded peril is effectively excluded. ACC provisions allow insurers to clarify coverage that is based on premiums paid.

- The use of ACC clauses began in the 1980’s in an effort by insurers to address uncertainty and inconsistent court rulings. For decades, courts struggled with the determination of whether coverage exists when excluded and covered perils interact to cause a loss. Courts attempted to address this issue by first applying the “efficient proximate cause doctrine” and then applying the “concurrent causation doctrine” imported from tort jurisprudence. As courts in some prominent jurisdictions began to require coverage using tort causation principles in construing policies that had been developed using narrower contract causation principles, insurers developed ACC clauses to clarify how a loss would be treated in a concurrent causation scenario in a manner consistent with the premiums paid for the coverage offered. ACC clauses do not “interact” with the claims practices of NFIP.

- The application of ACC clauses commonly arises in situations involving hurricane damage, where losses may be caused by both wind and water. The wind damage is usually covered by a homeowner’s insurance policy, but the damage caused by flood or rising water is typically excluded from coverage under the same policy. Most states allow ACC clauses in homeowner’s insurance policies. California and North Dakota are the only two states that have statutorily invalidated ACC clauses. Washington and West Virginia prohibit ACC clauses by adverse judicial decisions. When North Dakota invalidated ACC clauses in 2003, the number of claims per insured homes paid and the overall loss costs increased significantly. Insured costs are typically passed on to policyholders. Further, the number of insurers offering homeowner’s coverage in those jurisdictions declined. A study conducted in response to legislation in New York found that without ACC clauses, the state’s residents would pay higher premiums, mostly in areas susceptible to storm surge and flooding.
In addition to water damage exclusion provisions, a change in policy to ban ACC clauses would abrogate other provisions of an insurance policy which are either uninsurable under any circumstance or insurable under separately purchased coverage, such as perils for pollution, dishonest acts by the insured, wear and tear, war, electrical interruption, nuclear damage, earthquake, and failure to protect the property at time of loss. Insurers price their policies with the expectation that they will not pay for damage from a covered peril in combination with a non-covered peril. If ACC clauses were banned, an insurer would have to manage the increased exposure by: increasing premiums; purchasing additional reinsurance, and passing the costs on to policyholders; increasing deductibles, shifting more risk to the policyholders; or not renewing existing policies or writing less new business. To address these issues, consumers need to be educated about the limitations in coverage by disclosure and the need for additional coverage to fill any gaps, for example, flood coverage. Damage from water from the ground up (flood) is not covered; however, damage from wind along with water and damage from water used to put out a fire are covered. If an earthquake causes a fire and the fire burns the house, the fire damage is covered, though other earthquake-related damage is not.

Post-catastrophe mediation programs benefit both consumers and insurers in that they are a quick, impartial way to dispute and reach settlement through a neutral third party. Maryland should adopt a regulation similar to the mediation program that New Jersey adopted by regulation.

From MIA, the committee heard from the following individuals on the regulator’s perspective, including complaints from policyholders: Ms. Tinna Quigley, Director of Government Relations and Ms. Sandra Castagna, Associate Commissioner for Property and Casualty.

Until the 1960s, property insurance policies generally were limited to only one named peril: fire. Fire insurance policies were gradually expanded to include damage from other named perils, including lightning, windstorm, hail, explosion, riot, civil commotion, aircraft, vehicles, smoke, vandalism, malicious mischief, and breakage of glass. Only named perils were covered; all others were excluded. Starting in the early 1970s, insurers began changing to “all risks” policies that would cover all causes of loss, unless specifically excluded under gradually lengthening lists of excluded perils. Simultaneously, the burden of proof of coverage shifted from the insured to the insurer to prove that the cause of loss is an excluded peril. During that time, courts held that when covered risk and excluded risk constitute “concurrent proximate causes” of an accident, the insurer is liable so long as one of the causes is covered by the policy. Courts also held that, in determining whether a loss is within an exception in a policy, where there is
a concurrence of different causes, the "efficient proximate cause" – the one that sets others in motion – is the cause to which the loss is to be attributed, though the other causes may follow it, and operate more immediately in producing the disaster; this doctrine determination shifts the burden to the insured to show a named peril is the "efficient proximate cause," the primary cause of loss. The purpose of ACC clauses is to combat the misapplication of the concurrent causation doctrine from tort law to first-party property claims.

• The Insurance Services Office, Inc (ISO) introduced the ACC clause in its 1990 edition of the homeowner's insurance policy. Twenty years later, the 2010 edition reads: "We do not insure for loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss. These exclusions apply whether or not the loss event results in widespread damage or affects a substantial area." ACC clauses are now standard in nearly all Maryland property insurance policies.

• Reviewing the national situation, Maryland and 20 other states follow the "efficient proximate cause" doctrine but allow insurers to use ACC clauses to override the doctrine. Sixteen other states follow the "efficient proximate cause" doctrine but it is unknown whether they allow insurers to use ACC clauses. Three states reject the "efficient proximate cause" doctrine outright and allow insurers to use ACC clauses. Four other states reject the "efficient proximate cause" doctrine and prohibit insurers from using ACC clauses. Four states follow the "efficient proximate cause" doctrine and prohibit insurers from using ACC clauses, two by statute and two by case law. It is not clear how the remaining two states handle ACC clauses.

• MIA reviewed complaints based on NAICS standard data codes, including fire/allied lines and homeowners. In 2012, there were 696 complaints for all property insurance-related claims, an increase of 139% from 2010. In 2012, there were 453 complaints through MIA's Rapid Response Program, an increase of 71% from 2010. Forty-five of the complaints for all property insurance-related claims involved the application of the ACC clauses while 21 of the Rapid Response Program complaints involved the application of the ACC clauses. In 40 of the 45 all property insurance-related complaints, MIA upheld the insurers' determinations; in the remaining five complaints, the insurer reversed its position during the investigation and provided coverage.

• Maryland law does not require insurers to file disclosure notices or MIA to review and approve the notices. MIA issued a bulletin in order to obtain notices. In reviewing the notices, MIA observed that: (1) some insurers quote the policy language directly which
does little to explain anything to the policyholders; (2) some insurers itemize the exclusions contained in the basic policy which may be confusing to insureds who have purchased additional coverage by endorsement; (3) some insurers’ notices do not appear to be clear and specific and could be considered misleading; and (4) a few insurers provide an example to policyholders, making the notices appear more helpful.

- MIA prepared a comprehensive chart that provides information relating to mediation processes across the county. At least 12 states have post-disaster mediation regulations.

The committees heard from Mr. Donald Waters, Insurance Examiner, Claims and Appeals Branch, DHS/FEMA, on the handling of claims under NFIP when two or more factors affect or cause the loss:

- NFIP only handles flood claims. In New Jersey, from Tropical Storm Sandy, there was no coverage issue of wind versus flood. After determining the water line, FEMA covers the flood damage that is below the line and the homeowner’s insurance policy covers the wind damage that is above the line. Typically, this is easily distinguishable.

The People’s Insurance Counsel, Mr. Peter K. Killough, submitted a letter indicating that “ACC clauses are profoundly anti-consumer and lead to egregiously bad results for policyholders.” The letter states that “…insurers have increasingly relied upon ACC clauses contained in policies, which means that if a loss is caused by two or more perils, one that is covered by insurance and one that is excluded, then the entire loss is excluded, regardless of which peril is the primary cause or whether the perils occurred concurrently or in a sequence.” The letter summarizes several examples.

The committees expressed concern that, depending on the situation, insurers may not pay for damages from a covered peril when a non-covered peril also causes damage. They also expressed concern that premiums could increase if a ban on the ACC clause were adopted. Another concern to the committees is the impact of the federal Biggert-Waters Flood Insurance Reform Act of 2012 and NFIP’s recent implementation of that act, which is intended to raise rates on policyholders whose premiums have historically been heavily subsidized and have not reflected the true risk to their property.

**Licensing and Regulation**

During the 2013 session, the committee informally referred to interim study legislation on the licensing of foresters and the regulation of auctioneers. In response to the committee’s action, stakeholders met over the interim to discuss the State Board of Foresters’ impending sunset and the auctioneer industry’s difficulty complying with the Secondhand Precious Metal
Object Dealers and Pawnbrokers Act, respectively. The committee received a letter from the Department of Legislative Services providing information on various models of regulating foresters. The committee will continue to monitor both issues.

**Workers’ Compensation**

The committee formally referred to interim study legislation relating to retaliation against workers’ compensation claimants (House Bill 595 of 2013) and informally referred to interim study legislation on physician dispensing of pharmaceuticals (House Bill 174 of 2013). The Department of Legislative Services has conducted research on both of these issues and has distributed a memorandum to the committee on anti-retaliation statutes in other states. The Joint Committee on Workers’ Compensation Insurance and Benefit Oversight intends to discuss the physician dispensing issue at its December 11 meeting.

The committee may take up the status of other matters of concern in briefings early in the 2014 session.

The Economic Matters Committee wishes to thank those agencies and individuals who contributed their time and talent during this 2013 interim to inform and advise the committee.

Respectfully submitted,

Dereck E. Davis
Chairman

cc: Mr. Kårl S. Aro
    Mr. Warren G. Deschenaux
    Ms. Lynne B. Porter