Maryland
Hospital Association

Senate Bill 890- Insurance - Premium Receipts Tax - Exemption for Captive Insurance Procured by Nonprofit Hospitals and Health Care Systems

Position: ***Support with Amendments***
February 25, 2026
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support with amendments of Senate Bill 890.

SB 890, with proposed amendments, would create a clear, modern framework for how hospital-based captive insurance programs are treated under Maryland law. The bill confirms that when hospitals set aside their own money into a captive to prepare for future risks, that activity is not taxed. However, when hospitals use those funds to purchase actual insurance from an outside insurer, they will pay the existing 3% premium receipts tax. This structure both modernizes the law and increases state tax revenue through transactions that are not consistently taxed today, while preserving hospital financial stability and avoiding higher costs for patients.

This bill is a product of extensive conversations between the MIA, MHA, and Maryland hospitals that ensures the fair application of Maryland taxes while preserving the financial stability hospitals need to protect patients. The proposed amendments make the bill achieve this intent and therefore will change the fiscal impact, as described in the current fiscal note, from losing revenue to **positively increasing state tax revenue.**

Hospital-based captives are an important tool that hospitals use to manage risk in a way that protects patients and strengthens the quality of care. A captive is a separate company created by a hospital to hold money the hospital sets aside each year for potential future claims—like a dedicated safety fund. Hospitals contribute money into this fund each year, based on actuarial estimates of what future liability might be. Because hospitals face high levels of risk, these savings must be set aside in a structured, regulated way. If a patient is injured and the hospital is responsible, the money in the captive is used to pay the claim. If claims do not occur that year, the money stays within the health system and can be used to improve patient safety, reduce the chance of future harm, and support the hospital workforce.

Captives are especially important because hospitals carry risks that are very difficult or extremely expensive to insure through traditional insurance companies. These risks include medical malpractice liability, especially in areas such as obstetrics, neurosurgery, trauma services, and emergency care. They also include modern cybersecurity risks such as ransomware attacks, data breaches, and failures of electronic medical records systems. Because traditional insurance companies often will not cover these risks or will only do so at unaffordable prices,

hospitals need a reliable way to prepare financially for them. Captives fill this gap so that patients can continue to rely on critical services even when the commercial market cannot support those risks.

One of the major benefits of captives is that hospitals can use the unspent funds to make care safer. For example, captive reserves can support investments in patient-safety technology, such as improved monitoring systems, safer medication management tools, or new equipment designed to reduce medical errors. Hospitals can also use captive-supported funds to expand staff training programs that reduce harm, such as simulation training for surgical teams, education for nurses on high-risk procedures, or programs that help prevent falls, infections, and other avoidable complications. Captives also allow hospitals to conduct internal risk reviews and quality audits, which identify areas where improvements can reduce the likelihood of future injuries. In this way, captives help hospitals prevent harm before it occurs. Captives also help ensure dedicated funds are always available to compensate patients if an injury happens. Unlike commercial insurance premiums, which disappear once paid, funds in a captive remain available year after year. The hospital is fully responsible for paying any claims, and the captive provides a structured way to make sure those resources are there when patients need them.

Maryland's unique, regulated hospital payment system makes this stability especially important. The Health Services Cost Review Commission sets hospital rates and sets annual revenue for every Maryland hospital and health system. Hospitals cannot raise prices or seek new revenue to absorb unexpected costs. This means that any newly imposed or unanticipated expense must be absorbed directly into the hospital's fixed budget. Every dollar hospitals spend on unexpected costs reduces the resources available for patient care, staffing, technology, and safety improvements. A clear, predictable framework for how captives are treated under Maryland law is essential to ensure hospitals can continue providing high-quality care in every community.

Recently, the MIA and Maryland hospitals have had conversations about how premium receipts taxes should apply to Maryland hospitals' use of captives. SB 890, as amended, establishes a clear, fair framework, based on those conversations, on how these taxes should apply to Maryland hospitals' use of captives. **When hospitals are simply setting aside their own money into a captive to self-insure, that activity is not taxed. When hospitals use those captive funds to buy insurance from an outside insurer, they pay the state's existing 3% premium receipts tax.** This distinction reflects the reality of how captives operate, aligns the tax code with actual insurance transactions, and creates a stable system that works for both hospitals and the state.

By passing this legislation and adopting these amendments, the Committee will support patient safety, protect access to essential services, strengthen Maryland's health care system, and generate new ongoing revenue for the state without raising costs for Maryland families.

For these reasons, MHA urges a favorable with amendments report on SB 890.
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<u>Proposed Amendments and Explanations</u>:

Amendment 1: On page 2, strike §4–209(a)(3).

Amendment 2: On page 3, strike §4–211(a)(1).

Explanation for Amendments 1 and 2: These amendments restore §4–209 and §4–211 to their original structure.

Amendment 3: In §4–209 and §4–211, add a new section (A). (A) IN THIS SECTION, NONPROFIT HEALTH SYSTEM MEANS: (1) A NONPROFIT HOSPITAL AND ANY ENTITY AFFILIATED WITH THE HOSPITAL THROUGH OWNERSHIP, GOVERNANCE, MEMBERSHIP, CONTRACT, OR OTHER MEANS; (2) A PARENT CORPORATION OF ONE OR MORE NONPROFIT HOSPITALS AND ANY ENTITY AFFILIATED WITH THE PARENT CORPORATION THROUGH OWNERSHIP, GOVERNANCE, MEMBERSHIP, CONTRACT, OR OTHER MEANS;

Explanation: This creates a clear definition of hospitals and health systems as well as their affiliated entities. This amended definition will ensure that all captive insurers owned by non-profit hospitals, health systems, and their affiliated entities are subject to the 3% tax on premiums paid by the captive insurer or nonprofit health system.

Amendment 4: Amend §4–209(b)(1) as follows: (b)(C) (1) (I) **EXCEPT AS PROVIDED IN SUBSECTION (II)**, if an unauthorized insurer effects, continues, or renews insurance on a subject resident, located, or to be performed in the State, the unauthorized insurer shall pay to the Commissioner before March 1 a premium receipts tax of 3% of gross premiums. **(II) FOR UNAUTHORIZED INSURERS, INCLUDING CAPTIVE INSURERS, OF NONPROFIT HEALTH SYSTEMS FOR WHICH MARYLAND IS THE HOME STATE, THE UNAUTHORIZED INSURER SHALL PAY THE COMMISSIONER, BEFORE MARCH 1 OF THE NEXT CALENDAR YEAR, A PREMIUM RECEIPTS TAX OF 3% OF THE GROSS PREMIUMS THAT THE UNAUTHORIZED INSURER OR THE NONPROFIT MEDICAL SYSTEM IS CHARGED BY A REINSURER TO COVER A PORTION OF THE LIABILITY OF THE UNAUTHORIZED INSURER.**

Explanation: This amendment clarifies that nonprofit health systems or their captive insurers are responsible for paying the 3% tax on premiums charged by a reinsurer, not on the funds paid by nonprofit health systems to their captives. This amendment directly addresses the fiscal note and ensures this bill will generate positive tax revenue for the state.

Amendment 5: Amend §4–211(b)(1) and add subsection §4–211(C)(3), as follows: (b)(C) (1) **EXCEPT AS PROVIDED IN SUBSECTION (3)**, If an insured procures, continues, or renews insurance from an unauthorized insurer that is subject to a report under § 4–210 of this subtitle, a premium receipts tax of 3% of the gross premiums charged for the insurance is levied on the obligation, chose in action, or right represented by the premium charged for the insurance. (2) If

an insurance contract subject to the tax is canceled and rewritten, the additional premium, for purposes of the premium receipts tax, is the premium in excess of the unearned premium of the canceled insurance contract. **(3) FOR UNAUTHORIZED INSURERS, INCLUDING CAPTIVE INSURERS, OF NONPROFIT HEALTH SYSTEMS FOR WHICH MARYLAND IS THE HOME STATE, THE UNAUTHORIZED INSURER SHALL PAY THE COMMISSIONER, BEFORE MARCH 1 OF THE NEXT CALENDAR YEAR, A PREMIUM RECEIPTS TAX OF 3% OF THE GROSS PREMIUMS THAT THE UNAUTHORIZED INSURER OR THE NONPROFIT MEDICAL SYSTEM IS CHARGED BY A REINSURER TO COVER A PORTION OF THE LIABILITY OF THE OF THE UNAUTHORIZED INSURER.**

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