HOUSE BILL 1101

C4 0lr2844

By: **Delegate Elliott**
Introduced and read first time: February 17, 2010
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Insurance – Unfair Claim Settlement Practices – Third–Party Claims

FOR the purpose of altering the circumstances under which an unfair claim settlement practice is considered to have been committed to include failure to act in good faith, as defined under certain provisions of law, in settling any claim, including a third–party claim, under a policy of property and casualty insurance; altering the circumstances under which an unfair claim settlement practice, with the frequency to indicate a general business practice, is considered to have been committed to include failure to act in good faith, as defined under certain provisions of law, in settling any claim, including a third–party claim, under a policy of property and casualty insurance; providing that certain penalties apply to certain violations of certain provisions of law; providing for the application of this Act; and generally relating to unfair claim settlement practices under property and casualty insurance.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 27–303 and 27–304
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 27–305 and 27–1001(a)
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 – Insurance

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

27–303.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(3) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(4) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which payment is being made;

(5) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim;

(7) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(8) fail to comply with the provisions of Title 15, Subtitle 10A of this article; or

(9) fail to act in good faith, as defined under § 27–1001 of this title, in settling a first–party claim **OR A THIRD–PARTY CLAIM** under a policy of property and casualty insurance.

27–304.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan, when committed with the frequency to indicate a general business practice, to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) fail to acknowledge and act with reasonable promptness on communications about claims that arise under policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims that arise under policies;

(4) refuse to pay a claim without conducting a reasonable investigation based on all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) fail to make a prompt, fair, and equitable good faith attempt, to settle claims for which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would expect to be entitled after studying written or printed advertising material accompanying, or made part of, an application;

(9) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(10) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which the payment is being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in order to compel insureds or claimants to accept a settlement or compromise less than the amount awarded in arbitration;

(12) delay an investigation or payment of a claim by requiring a claimant or a claimant's licensed health care provider to submit a preliminary claim report and subsequently to submit formal proof of loss forms that contain substantially the same information;

(13) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(14) fail to provide promptly a reasonable explanation of the basis for denial of a claim or the offer of a compromise settlement;

(15) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(16) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(17) fail to comply with the provisions of Title 15, Subtitle 10A of this article; or

(18) fail to act in good faith, as defined under § 27–1001 of this title, in settling a first–party claim **OR A THIRD–PARTY CLAIM** under a policy of property and casualty insurance.

27–305.

(a) The Commissioner may impose a penalty:

(1) not exceeding $2,500 for each violation of § 27–303 of this subtitle or a regulation adopted under § 27–303 of this subtitle; and

(2) not exceeding $125,000 for each violation of § 27–303(9) of this subtitle or a regulation adopted under § 27–303(9) of this subtitle.

(b) The penalty for a violation of § 27–304 of this subtitle is as provided in §§ 1–301, 4–113, 4–114, and 27–103 of this article.

(c) (1) On finding a violation of this subtitle, the Commissioner may require an insurer or nonprofit health service plan to make restitution to each claimant who has suffered actual economic damage because of the violation.

(2) Subject to paragraph (3) of this subsection, restitution may not exceed the amount of actual economic damage sustained, subject to the limits of any applicable policy.

(3) For a violation of § 27–303(9) of this subtitle, the Commissioner may require restitution to an insured for the following:

(i) actual damages, which actual damages may not exceed the limits of any applicable policy;

(ii) expenses and litigation costs incurred by the insured in pursuing an administrative complaint under § 27–303(9) of this subtitle, including reasonable attorney's fees; and

(iii) interest on all actual damages, expenses, and litigation costs incurred by the insured computed:

1. at the rate allowed under § 11–107(a) of the Courts Article; and

2. from the date on which the insured's claim would have been paid if the insurer acted in good faith.

(4) The amount of attorney's fees recovered from an insurer under paragraph (3) of this subsection may not exceed one–third of the actual damages recovered.

27–1001.

(a) In this section, "good faith" means an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim.

SECTION 2. AND BE IT FURTHER ENACTED, That the provisions of this Act providing for administrative penalties and license sanctions that may be imposed by the Maryland Insurance Commissioner apply only to an act or omission occurring on or after the effective date of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010.