
By: **Senator Della**

Introduced and read first time: February 4, 2000

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance - Carriers - Records of Claims**

3 FOR the purpose of requiring certain insurance carriers to maintain a certain record
4 of claims submitted to the carriers; requiring the carriers to submit certain
5 reports to the Maryland Insurance Commissioner at certain times; specifying
6 the contents of the reports; authorizing the Commissioner to take certain
7 actions after reviewing the reports; authorizing the Commissioner to find that a
8 carrier has committed an unfair claim settlement practice and to impose certain
9 penalties based on the information contained in the reports; requiring certain
10 financial examinations and market conduct studies to include an examination of
11 a carrier's compliance with this Act; defining a certain term; and generally
12 relating to records of claims submitted to insurance carriers.

13 BY adding to
14 Article - Insurance
15 Section 15-1009
16 Annotated Code of Maryland
17 (1997 Volume and 1999 Supplement)

18 BY repealing and reenacting, without amendments,
19 Article - Insurance
20 Section 27-304 and 27-305
21 Annotated Code of Maryland
22 (1997 Volume and 1999 Supplement)

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

25 **Article - Insurance**

26 15-1009.

27 (A) IN THIS SECTION, "CARRIER" MEANS:

28 (1) AN INSURER;

- 1 (2) A NONPROFIT HEALTH SERVICE PLAN;
2 (3) A HEALTH MAINTENANCE ORGANIZATION;
3 (4) A DENTAL PLAN ORGANIZATION; OR
4 (5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS
5 SUBJECT TO REGULATION BY THE STATE.

6 (B) (1) EACH CARRIER SHALL MAINTAIN A RECORD OF THE NUMBER OF
7 CLAIMS, BY CATEGORY:

8 (I) THAT ARE PAID WITHIN 30 DAYS AFTER THEIR INITIAL
9 SUBMISSION;

10 (II) THAT ARE DENIED BECAUSE THEY ARE FOR A NONCOVERED
11 SERVICE OR BECAUSE THE SERVICE WAS PROVIDED BY A HEALTH CARE PROVIDER
12 NOT ELIGIBLE FOR REIMBURSEMENT;

13 (III) THAT ARE DENIED AT THEIR INITIAL SUBMISSION BECAUSE OF
14 IMPROPER CODING;

15 (IV) THAT ARE DENIED AT THEIR INITIAL SUBMISSION BECAUSE OF
16 INCORRECT ENROLLMENT INFORMATION;

17 (V) THAT ARE NOT PAID WITHIN 30 DAYS AFTER THEIR INITIAL
18 SUBMISSION BECAUSE ADDITIONAL DOCUMENTATION OR INFORMATION IS
19 REQUIRED OR REQUESTED;

20 (VI) THAT ARE PAID AFTER RECEIPT OF ADDITIONAL
21 DOCUMENTATION OR INFORMATION;

22 (VII) THAT ARE DENIED AFTER RECEIPT OF ADDITIONAL
23 DOCUMENTATION OR INFORMATION;

24 (VIII) ON WHICH THE INTEREST PAYMENTS PROVIDED FOR IN §
25 15-1005 OF THIS SUBTITLE HAVE BEEN PAID, AND THE AGGREGATE AMOUNT OF
26 INTEREST PAID; AND

27 (IX) THAT ARE DENIED, OR REPORTED TO THE INSURANCE FRAUD
28 DIVISION IN THE ADMINISTRATION, BECAUSE THE CARRIER HAS REASON TO
29 BELIEVE THAT THE CLAIM HAS BEEN SUBMITTED FRAUDULENTLY.

30 (2) THE RECORD REQUIRED UNDER PARAGRAPH (1) OF THIS
31 SUBSECTION:

32 (I) SHALL BE IN A FORM REQUIRED BY THE COMMISSIONER; AND

33 (II) SHALL BE AUDITED ANNUALLY BY A PRIVATE AUDITING FIRM
34 AT THE EXPENSE OF THE CARRIER.

1 (C) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH CARRIER SHALL SUBMIT TO
2 THE COMMISSIONER AN ANNUAL REPORT THAT CONTAINS:

3 (1) THE AUDITED RECORD REQUIRED UNDER SUBSECTION (B) OF THIS
4 SECTION FOR THE PRECEDING CALENDAR YEAR; AND

5 (2) ANY OTHER INFORMATION THE COMMISSIONER MAY REQUIRE.

6 (D) AFTER REVIEWING A CARRIER'S ANNUAL REPORT, THE COMMISSIONER
7 MAY:

8 (1) REQUIRE THE CARRIER TO IMPLEMENT A PLAN OF REMEDIAL
9 ACTION; OR

10 (2) REQUIRE THAT THE CARRIER'S CLAIMS PROCESSING PROCEDURES
11 BE MONITORED BY A PRIVATE AUDITING FIRM AT THE EXPENSE OF THE CARRIER
12 FOR A PERIOD OF TIME THAT THE COMMISSIONER DEEMS APPROPRIATE.

13 (E) EACH FINANCIAL EXAMINATION AND MARKET CONDUCT STUDY OF A
14 CARRIER PERFORMED IN ACCORDANCE WITH § 2-205 OF THIS ARTICLE SHALL
15 INCLUDE AN EXAMINATION OF THE CARRIER'S COMPLIANCE WITH THE PROVISIONS
16 OF THIS SECTION.

17 (F) (1) IN ADDITION TO THE ANNUAL REPORT REQUIRED UNDER
18 SUBSECTION (C) OF THIS SECTION, EACH CARRIER SHALL SUBMIT TO THE
19 COMMISSIONER, AT LEAST QUARTERLY, A REPORT THAT CONTAINS THE
20 INFORMATION DESCRIBED IN SUBSECTION (B)(1)(I) THROUGH (IX) OF THIS SECTION
21 AND ANY OTHER INFORMATION THE COMMISSIONER MAY REQUIRE.

22 (2) AFTER REVIEWING A REPORT SUBMITTED UNDER PARAGRAPH (1) OF
23 THIS SUBSECTION, THE COMMISSIONER:

24 (I) MAY REQUIRE AN IMMEDIATE AUDIT OF THE CARRIER BY A
25 PRIVATE AUDITING FIRM AT THE EXPENSE OF THE CARRIER; AND

26 (II) AFTER REVIEWING THE AUDIT, MAY PROCEED WITH THE
27 REMEDIATION OR MONITORING PROCEDURE PROVIDED FOR IN SUBSECTION (D) OF
28 THIS SECTION.

29 (G) BASED ON THE INFORMATION CONTAINED IN A REPORT SUBMITTED TO
30 THE COMMISSIONER UNDER THIS SECTION, THE COMMISSIONER MAY FIND A
31 VIOLATION OF § 27-304 OF THIS ARTICLE AND MAY IMPOSE THE PENALTIES
32 PROVIDED IN § 27-305 OF THIS ARTICLE.

33 27-304.

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

- 1 (1) misrepresent pertinent facts or policy provisions that relate to the
2 claim or coverage at issue;
- 3 (2) fail to acknowledge and act with reasonable promptness on
4 communications about claims that arise under policies;
- 5 (3) fail to adopt and implement reasonable standards for the prompt
6 investigation of claims that arise under policies;
- 7 (4) refuse to pay a claim without conducting a reasonable investigation
8 based on all available information;
- 9 (5) fail to affirm or deny coverage of claims within a reasonable time
10 after proof of loss statements have been completed;
- 11 (6) fail to make a prompt, fair, and equitable good faith attempt, to settle
12 claims for which liability has become reasonably clear;
- 13 (7) compel insureds to institute litigation to recover amounts due under
14 policies by offering substantially less than the amounts ultimately recovered in
15 actions brought by the insureds;
- 16 (8) attempt to settle a claim for less than the amount to which a
17 reasonable person would expect to be entitled after studying written or printed
18 advertising material accompanying, or made part of, an application;
- 19 (9) attempt to settle a claim based on an application that is altered
20 without notice to, or the knowledge or consent of, the insured;
- 21 (10) fail to include with each claim paid to an insured or beneficiary a
22 statement of the coverage under which the payment is being made;
- 23 (11) make known to insureds or claimants a policy of appealing from
24 arbitration awards in order to compel insureds or claimants to accept a settlement or
25 compromise less than the amount awarded in arbitration;
- 26 (12) delay an investigation or payment of a claim by requiring a claimant
27 or a claimant's licensed health care provider to submit a preliminary claim report and
28 subsequently to submit formal proof of loss forms that contain substantially the same
29 information;
- 30 (13) fail to settle a claim promptly whenever liability is reasonably clear
31 under one part of a policy, in order to influence settlements under other parts of the
32 policy;
- 33 (14) fail to provide promptly a reasonable explanation of the basis for
34 denial of a claim or the offer of a compromise settlement;
- 35 (15) refuse to pay a claim for an arbitrary or capricious reason based on
36 all available information;

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

3 (17) fail to comply with the provisions of Title 15, Subtitle 10A of this
4 article.

5 27-305.

6 (a) The Commissioner may impose a penalty not exceeding \$2,500 for each
7 violation of § 27-303 of this subtitle or a regulation adopted under § 27-303 of this
8 subtitle.

9 (b) The penalty for a violation of § 27-304 of this subtitle is as provided in §§
10 1-301, 4-113, 4-114, and 27-103 of this article.

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

14 (2) Restitution may not exceed the amount of actual economic damage
15 sustained, subject to the limits of any applicable policy.

16 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
17 October 1, 2000.