SENATE BILL 45

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(PRE-FILED)

By: **Chairman, Finance Committee (Departmental - Insurance Administration, Maryland)**
Requested: October 26, 2000
Introduced and read first time: January 10, 2001
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Insurance - Unfair Claim Settlement Practices

FOR the purpose of establishing certain practices by insurers as unfair claim settlement practices; and generally relating to unfair claim settlement practices.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 27-303
Annotated Code of Maryland
(1997 Volume and 2000 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 27-304
Annotated Code of Maryland
(1997 Volume and 2000 Supplement)

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

Article - Insurance

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 ANY PART OF 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; [or]

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

(9) FAIL TO ACKNOWLEDGE AND ACT WITH REASONABLE PROMPTNESS ON COMMUNICATIONS ABOUT CLAIMS THAT ARISE UNDER POLICIES;

(10) REFUSE TO PAY A CLAIM WITHOUT CONDUCTING A REASONABLE INVESTIGATION BASED ON ALL AVAILABLE INFORMATION;

(11) FAIL TO MAKE A PROMPT, FAIR, AND EQUITABLE GOOD FAITH ATTEMPT, TO SETTLE CLAIMS FOR WHICH LIABILITY HAS BECOME REASONABLY CLEAR; OR

(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.

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; or

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

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2001.