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§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.

(b) This section applies only to actions under § 3–1701 of the Courts Article.

(c) (1) Except as provided in paragraph (2) of this subsection, a person may not bring or pursue an action under § 3–1701 of the Courts Article in a court unless the person complies with this section.

(2) Paragraph (1) of this subsection does not apply to an action:

(i) within the small claim jurisdiction of the District Court under § 4–405 of the Courts Article;

(ii) if the insured and the insurer agree to waive the requirement under paragraph (1) of this subsection; or

(iii) under a commercial insurance policy on a claim with respect to which the applicable limit of liability exceeds $1,000,000.

(d) (1) A complaint stating a cause of action under § 3–1701 of the Courts Article shall first be filed with the Administration.

(2) The complaint shall:

(i) be accompanied by each document that the insured has submitted to the insurer for proof of loss;

(ii) specify the applicable insurance coverage and the amount of the claim under the applicable coverage; and

(iii) state the amount of actual damages, and the claim for expenses and litigation costs described under subsection (e)(2) of this section.

(3) The Administration shall forward the filing to the insurer.

(4) Within 30 days after the date the filing is forwarded to the insurer by the Administration, the insurer shall:

(i) file with the Administration, except for good cause shown, a written response together with a copy of each document from the insurer's claim file that enables reconstruction of the insurer's activities relative to the insured's claim, including documentation of each pertinent communication, transaction, note, work paper, claim form, bill, and explanation of benefits form relative to the claim; and

(ii) mail to the insured a copy of the response and, except for good cause shown, each document from the insurer's claim file that enables reconstruction of the insurer's activities relative to the insured's claim, including documentation of each pertinent communication, transaction, note, work paper, claim form, bill, and explanation of benefits form relative to the claim.

(e) (1) (i) Within 90 days after the date the filing was received by the Administration, the Administration shall issue a decision that determines:

1. whether the insurer is obligated under the applicable policy to cover the underlying first–party claim;

2. the amount the insured was entitled to receive from the insurer under the applicable policy on the underlying covered first–party claim;

3. whether the insurer breached its obligation under the applicable policy to cover and pay the underlying covered first–party claim, as determined by the Administration;

4. whether an insurer that breached its obligation failed to act in good faith; and

5. the amount of damages, expenses, litigation costs, and interest, as applicable and as authorized under paragraph (2) of this subsection.

(ii) The failure of the Administration to issue a decision within the time specified in subparagraph (i) of this paragraph shall be considered a determination that the insurer did not breach any obligation to the insured.

(2) With respect to the determination of damages under paragraph (1)(i)5 of this subsection:

(i) if the Administration finds that the insurer breached an obligation to the insured, the Administration shall determine the obligation of the insurer to pay:

1. actual damages, which actual damages may not exceed the limits of any applicable policy; and

2. interest on all actual damages incurred by the insured computed:

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

B. from the date on which the insured's claim should have been paid; and

(ii) if the Administration also finds that the insurer failed to act in good faith, the Administration shall also determine the obligation of the insurer to pay:

1. expenses and litigation costs incurred by the insured, including reasonable attorney's fees, in pursuing recovery under this subtitle; and

2. interest on all expenses and litigation costs incurred by the insured computed:

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

B. from the applicable date or dates on which the insured's expenses and costs were incurred.

(3) An insurer may not be found to have failed to act in good faith under this section solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer.

(4) The amount of the attorney's fees determined to be payable to an insured under paragraph (2) of this subsection may not exceed one–third of the actual damages payable to the insured.

(5) The Administration shall serve a copy of the decision on the insured and the insurer in accordance with § 2–204(c) of this article.

(f) (1) If a party receives an adverse decision, the party shall have 30 days after the date of service of the Administration's decision to request a hearing.

(2) All hearings requested under this section shall:

(i) be referred by the Commissioner to the Office of Administrative Hearings for a final decision under Title 10, Subtitle 2 of the State Government Article;

(ii) be heard de novo; and

(iii) result in a final decision that makes the determinations set forth in subsection (e) of this section.

(3) If no administrative hearing is requested in accordance with paragraph (1) of this subsection, the decision issued by the Administration shall become a final decision.

(g) (1) If a party receives an adverse decision, the party may appeal a final decision by the Administration or an administrative law judge under this section to a circuit court in accordance with § 2–215 of this article and Title 10, Subtitle 2 of the State Government Article.

(2) (i) This paragraph applies only if more than one party receives an adverse decision from the Administration.

(ii) If a party requests a hearing before the Office of Administrative Hearings and another party files an appeal to a circuit court:

1. jurisdiction over the request for hearing is transferred to the circuit court;

2. the request for hearing, the Administration's decision, and the Administration's case file, including the complaint, response, and all documents submitted to the Administration, shall be transmitted promptly to the circuit court; and

3. the request for hearing shall be docketed in the circuit court and consolidated for trial with the appeal.

(3) Notwithstanding any other provision of law, an appeal to a circuit court under this section shall be heard de novo.

(h) On or before January 1 of each year beginning in 2009, in accordance with § 2–1257 of the State Government Article, the Administration shall report to the General Assembly on the following for the prior fiscal year:

(1) the number and types of complaints under this section or § 3–1701 of the Courts Article from insureds regarding first–party insurance claims under property and casualty insurance policies;

(2) the number and types of complaints under this section or § 3–1701 of the Courts Article from insureds regarding first–party insurance claims under individual disability insurance policies;

(3) the administrative and judicial dispositions of the complaints described in items (1) and (2) of this subsection;

(4) the number and types of regulatory enforcement actions instituted by the Administration for unfair claim settlement practices under § 27–303(9) or § 27–304(18) of this title; and

(5) the administrative and judicial dispositions of the regulatory enforcement actions for unfair claim settlement practices described under item (4) of this subsection.

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