Maryland Code regarding Unfair Claims Settlement Practices

Maryland Code:

Insurance
TITLE 27. UNFAIR TRADE PRACTICES AND OTHER PROHIBITED PRACTICES
SUBTITLE 3. UNFAIR CLAIM SETTLEMENT PRACTICES

§ 27-301. Intent and effect of subtitle.

(a) Intent of subtitle.- The intent of this subtitle is to provide an additional administrative remedy to a claimant for a violation of this subtitle or a regulation that relates to this subtitle.

(b) Effect of subtitle.-

(1) This subtitle provides administrative remedies only.

(2) This subtitle does not provide or prohibit a private right or cause of action to, or on behalf of, a claimant or other person in any state.

(3) This subtitle does not impair the right of a person to seek redress in law or equity for conduct that otherwise is actionable.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]

§ 27-302. Scope of subtitle.

(a) Policies covered.- This subtitle applies to each individual or group policy, contract, or certificate of an insurer or nonprofit health service plan that:

(1) is delivered or issued in the State;

(2) is issued to a group that has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) Exclusions.- This subtitle does not apply to:

(1) reinsurance;

(2) workers' compensation insurance; or

(3) surety insurance.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]

§ 27-303. Unfair claim settlement practices - In general.

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; or

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

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; ch. 755.]

§ 27-304. Same - General business practice.

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.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; ch. 755; 1999, ch. 71.]

§ 27-304.1. Regulations.

The Commissioner shall adopt regulations that establish standards and procedures for:

(1) the settlement of claims involving the total loss of a private passenger motor vehicle; and

(2) the determination of the private passenger motor vehicle's total loss value.

[2003, ch. 439.]

§ 27-305. Penalties.

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

(b) For violation of § 27-304.- 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) Restitution.-

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

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 755; 1999, ch. 71.]

27-306. Appeals.

An appeal from an order issued by the Commissioner under this subtitle shall be taken in accordance with § 2-215 of this article.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]