SENATE BILL 801

D3, C4 0lr2994

By: **Senator Reilly**
Introduced and read first time: February 3, 2020
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Civil Action – Surety Insurance – Failure to Act in Good Faith

FOR the purpose of authorizing the recovery of actual damages, expenses, litigation costs, and interest in obligee claims against surety insurance providers under certain circumstances; applying certain provisions of law on unfair claim settlement practices to surety insurance; requiring an obligee to comply with certain procedures before the obligee brings a certain claim against a surety insurance provider; requiring the Maryland Insurance Administrator to include certain information in a report that the Administrator provides annually to the General Assembly; making conforming changes; defining certain terms; providing for the application of this Act; and generally relating to proceedings concerning surety insurers who fail to act in good faith in settling obligees' claims under certain circumstances.

BY repealing and reenacting, with amendments,
Article – Courts and Judicial Proceedings
Section 3–1701
Annotated Code of Maryland
(2013 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 1–101(a) and (oo)
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 27–302 through 27–304 and 27–1001
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

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

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

Article – Courts and Judicial Proceedings

3–1701.

(a) (1) In this subtitle the following words have the meanings indicated.

(2) "Casualty insurance" has the meaning stated in § 1–101 of the Insurance Article.

(3) "Commercial insurance" has the meaning stated in § 27–601 of the Insurance Article.

(4) (i) "Disability insurance" means insurance that provides for lost income, revenue, or proceeds in the event that an illness, accident, or injury results in a disability that impairs an insured's ability to work or otherwise generate income, revenue, or proceeds that the insurance is intended to replace.

(ii) "Disability insurance" does not include payment for medical expenses, dismemberment, or accidental death.

(5) "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.

(6) "Insurer" has the meaning stated in § 1–101 of the Insurance Article.

(7) **"OBLIGEE" MEANS A PERSON WHO IS THE RECIPIENT OF AN OBLIGATION UNDER A SURETY INSURANCE POLICY.**

(8) "Property insurance" has the meaning stated in § 1–101 of the Insurance Article.

(9) "SURETY INSURANCE" HAS THE MEANING STATED IN § 1–101 OF THE INSURANCE ARTICLE.

(b) This subtitle applies only to **[**first–party**]:**

(1) FIRST–PARTY claims under property and casualty insurance policies or individual disability insurance policies issued, sold, or delivered in the State**; AND**

(2) OBLIGEE CLAIMS UNDER SURETY INSURANCE POLICIES ISSUED, SOLD, OR DELIVERED IN THE STATE.

(c) (1) Except as provided in paragraph (2) of this subsection, a party may not file an action under this subtitle before the date of a final decision under § 27–1001 of the Insurance Article.

(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 this article;

(ii) If the insured**, OR OBLIGEE,** 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) This section applies only in a civil action:

(1) (i) To determine the coverage that exists under the insurer's insurance policy**, OR SURETY POLICY**; or

(ii) To determine the extent to which the insured**, OR OBLIGEE,** is entitled to receive payment from the insurer for a covered loss;

(2) That alleges that the insurer failed to act in good faith; and

(3) That seeks, in addition to the actual damages under the policy, to recover expenses and litigation costs, and interest on those expenses or costs, under subsection (e) of this section.

(e) Notwithstanding any other provision of law, if the trier of fact in an action under this section finds in favor of the insured**, OR OBLIGEE,** and finds that the insurer failed to act in good faith, the insured**, OR OBLIGEE,** may recover from the insurer:

(1) Actual damages, which actual damages may not exceed the limits of the applicable policy;

(2) Expenses and litigation costs incurred by the insured**, OR OBLIGEE,** in an action under this section or under § 27–1001 of the Insurance Article or both, including reasonable attorney's fees; and

(3) Interest on all actual damages, expenses, and litigation costs incurred by the insured**, OR OBLIGEE**, computed:

(i) At the rate allowed under § 11–107(a) of this article; and

(ii) From the date on which the insured's**, OR OBLIGEE'S,** claim would have been paid if the insurer acted in good faith.

(f) 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**, OR OBLIGEE,** is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer.

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

(h) The clerk of the court shall file a copy of the verdict or any other final disposition of an action under this section with the Maryland Insurance Administration.

(i) This section does not limit the right of any person to maintain a civil action for damages or other remedies otherwise available under any other provision of law.

(j) If a party to the proceeding elects to have the case tried by a jury in accordance with the Maryland Rules, the case shall be tried by a jury.

Article – Insurance

1–101.

(a) In this article the following words have the meanings indicated.

(oo) "Surety insurance" includes:

(1) fidelity insurance, which is insurance that guarantees the fidelity of persons that hold positions of public or private trust;

(2) insurance that guarantees the performance of contracts other than insurance contracts;

(3) insurance that guarantees the execution of bonds, undertakings, and contracts of suretyship; and

(4) insurance that indemnifies banks, bankers, brokers, or financial corporations or associations against loss from any cause of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts, other valuable papers, documents, money, precious metals, articles made from precious metals, jewelry, watches, necklaces, bracelets, gems, and precious and semi–precious stones, including loss during transportation by messenger or in armored motor vehicles, but not against other risks of transportation or navigation, and insurance against loss or damage to a bank's, banker's, broker's, or financial corporation's or association's premises or furniture, fixtures, equipment, safes, and vaults on the premises caused by burglary, robbery, theft, vandalism, or malicious mischief, or attempted burglary, robbery, theft, vandalism, or malicious mischief.

27–302.

(a) This subtitle applies to each individual or group policy, contract, or certificate of an insurer, nonprofit health service plan, or health maintenance organization 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) This subtitle does not apply to:

(1) reinsurance; **OR**

(2) workers' compensation insurance**[**; or

(3) surety insurance**]**.

27–303.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization 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**, OR OBLIGEE** 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;

(9) fail to act in good faith, as defined under § 27–1001 of this title, in settling**:**

(I) a first–party claim under a policy of property and casualty insurance**; OR**

(II) AN OBLIGEE CLAIM UNDER A POLICY OF SURETY INSURANCE; or

(10) fail to comply with the provisions of § 16–118 of this article.

27–304.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization, 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**, OR TO PERFORM UNDER A SURETY INSURANCE POLICY,** 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**, OR OBLIGEES,** 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**, OR OBLIGEE**;

(10) fail to include with each claim paid to an insured **[**or**],** beneficiary**, OR OBLIGEE** 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**:**

(I) a first–party claim under a policy of property and casualty insurance**; OR**

(II) AN OBLIGEE CLAIM UNDER A POLICY OF SURETY INSURANCE.

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**, OR OBLIGEE,** and the insurer agree to waive the requirement under paragraph (1) of this subsection; or

(iii) under a commercial insurance policy**, OR SURETY 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**, OR OBLIGEE,** 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**, OR OBLIGEE'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**, OR OBLIGEE,** 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**, OR OBLIGEE'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**, OR THE UNDERLYING CLAIM OF THE OBLIGEE**;

2. the amount the insured**, OR OBLIGEE,** was entitled to receive from the insurer under the applicable policy on the underlying covered first–party claim**, OR THE UNDERLYING COVERED CLAIM OF THE OBLIGEE**;

3. whether the insurer breached its obligation under the applicable policy to cover and pay the underlying covered first–party claim**, OR THE UNDERLYING COVERED CLAIM OF THE OBLIGEE**, 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**, OR OBLIGEE**.

(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**, OR OBLIGEE,** computed:

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

B. from the date on which the insured's**, OR OBLIGEE'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**, OR OBLIGEE**, including reasonable attorney's fees, in pursuing recovery under this subtitle; and

2. interest on all expenses and litigation costs incurred by the insured**, OR OBLIGEE,** 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**, OR OBLIGEE,** 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**, OR OBLIGEE,** under paragraph (2) of this subsection may not exceed one–third of the actual damages payable to the insured**, OR OBLIGEE**.

(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;

(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**:**

(I) insureds regarding first–party insurance claims under property and casualty insurance policies**; AND**

(II) OBLIGEES REGARDING CLAIMS UNDER SURETY 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.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any claims by an obligee under a surety insurance policy alleged to have occurred before the effective date of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020.