

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

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Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of property and casualty claims arising under contracts or certificates issued to residents of the State. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create nor imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate any change of position.

Drafting Note: Any jurisdiction which may choose to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has separately promulgated an Unfair Life, Accident and Health Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

- A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
- B. "Claim file" means any retrievable electronic file, paper file or combination of both;
- C. "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
- D. "Days" means calendar days;
- E. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;
- F. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;
- G. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

- H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.
- I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;
- J. "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and
- K. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by the Commissioner's duly appointed designees. To aid in such examination:

- A. The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.
- B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.
- C. Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.
- D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Section 5. Misrepresentation of Policy Provisions

- A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.
- B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
- C. A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions in the claim file.
- D. No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition, or claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.
- E. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

- F. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Section 6. Failure to Acknowledge Pertinent Communications

- A. Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
- B. Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within twenty-one (21) days of receipt of such inquiry, furnish the department with an adequate response to the inquiry in duplicate.
- C. An appropriate reply shall be made within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
- D. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within fifteen (15) days of notification of a claim shall constitute compliance with Subsection A of this section.

Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

- A. Within twenty-one (21) days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by Section 4.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

- B. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within twenty-one (21) days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

- C. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.
- D. No insurer shall continue negotiations for settlement of a claim directly with a claimant who is not legally represented, if the claimant's rights may be affected by a statute of limitations, unless the insurer has given the claimant written notice of such limitation. Notice shall be given to first party claimants at least thirty (30) days and to third party claimants at least sixty (60) days before the date on which such time limit may expire.

- E. No insurer shall make statements indicating that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.
- F. The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute and where the payee is known should be tendered within thirty (30) days if such payment would terminate the insurer's known liability under that individual coverage.
- G. No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.
- H. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

- A. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:
 - (1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
 - (2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:
 - (a) The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or
 - (b) The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to Subparagraph (a); or
 - (c) One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to (a) and (b) above; or
 - (d) Any source for determining statistically valid fair market values that meet all of the following criteria:
 - (i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;
 - (ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years taking into account the values of all major options for such vehicles; and

- (iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.
- (e) Right of Recourse—If the insurer is notified within thirty-five (35) days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for the market value, the company shall reopen its claim file and the following procedures shall apply:
 - (i) The company may locate a comparable vehicle by the same manufacturer, same year, similar body style and similar options and price range for the insured for the market value determined by the company at the time of settlement. Any such vehicle must be available through licensed dealers;
 - (ii) The company shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;
 - (iii) The company may elect to offer a replacement in accordance with the provisions set forth in Section 8A(1); or
 - (iv) The company may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The company is not required to take action under this subsection if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same year, similar body style and similar options in as good or better condition as the total loss vehicle which could have been purchased for the market value determined by the company before applicable deductions. The documentation shall include the vehicle identification number.

- (3) When a first party automobile total loss is settled on a basis which deviates from the methods described in Subsection A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for the settlement shall be fully explained to the first party claimant.
- B. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy.
- C. Insurers shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.
- D. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

- E. Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which he obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repairers, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications.
- F. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.
- G. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
- H. Storage and Towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges and documentation of the denial as required by Section 4. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured.
- I. Betterment deductions are allowable only if the deductions:
 - (1) (a) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle;
 - (b) Reflect the general overall condition of the vehicle, considering its age, for either or both:
 - (i) The wear and tear or rust, limited to no more than a deduction of \$1,000;
 - (ii) Missing parts, limited to no more of a deduction than the replacement costs of the part or parts.
 - (2) Any deductions set forth in (1)(a) or (b) above must be measurable, itemized, specified as to dollar amount and documented in the claim file.
 - (3) No insurer shall require the insured or claimant to supply parts for replacement.
- J. Replacement Crash Parts
 - (1) Purpose

The purpose of this subsection is to set forth standards for the prompt, fair and equitable settlements applicable to automobile insurance with regard to the use of replacement crash parts. It is intended to regulate the use of replacement crash parts in automobile damage repairs which insurers pay for on their insured's vehicle. It also requires that all replacement crash parts, as defined in this section, be identified and be of the same quality as the original part.
 - (2) "Replacement crash part," for purposes of this regulation, means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

(3) Identification

All replacement crash parts, which are subject to this section and manufactured after the effective date of this section, shall carry sufficient permanent non-removable identification so as to identify its manufacturer. Such identification shall be accessible to the extent possible after installation.

(4) Like Kind and Quality

No insurer shall require the use of replacement crash parts in the repair of an automobile unless the replacement crash part is at least equal in kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of replacement crash parts shall consider the cost of any modifications which may become necessary when making the repair.

Drafting Note: Subsection J incorporates the fundamental provisions of the NAIC 1987 “After Market Parts Model Regulation” and makes requirements applicable to all replacement crash parts. Adoption of this subsection is the recommended approach.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

A. When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

- (1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss. The insured shall not have to pay for betterment nor any other cost except for the applicable deductible.
- (2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible, if any.

B. Actual Cash Value:

- (1) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured’s request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.
- (2) In cases in which the insured’s interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured’s request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 179-184 (adopted).

1991 Proc. I 9, 16, 192-193, 206-211 (amended and reprinted).

This document replaces a model named “Unfair Claims Settlement Practices Model Regulation.”

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).

1980 Proc. II 22, 26, 906, 930, 936 (amended).

1981 Proc. I 47, 51, 255, 258, 263 (amended).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-124 (2003); r. 482-1-125 (2003/2014).	
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 26.010 to 26.300 (1989/2015).	
American Samoa	NO CURRENT ACTIVITY	
Arizona	ARIZ. ADMIN. CODE § 20-6-801 (1981).	
Arkansas	ARK. CODE R. § 43 (1989/2001).	
California		CAL. CODE REGS. tit. 10, §§ 2695.1 to 2695.13 (1993/2013).
Colorado		5 COLO. CODE REGS. § 1-14 (2001); § 2-15 (2004).
Connecticut	NO CURRENT ACTIVITY	
Delaware		18 DEL. CODE REGS. § 903 (2001/2003); § 1310 (1998/2005); DOM./FOR. INSUR. BULLETIN 61 (2013).
District of Columbia	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69O-166.021 to 69O-166.031 (1992/2004).	FLA. STAT. §§ 626.9743 to 626.9744 (2004); FLA. ADMIN. CODE ANN. r. 69O-220.001 to 69O-220.201 (1993) (code of ethics of insurance adjusters).
Georgia		GA. COMP. R. & REGS. 120-2-52 (1993).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	NO CURRENT ACTIVITY	
Illinois		ILL. ADMIN. CODE tit. 50, §§ 919.10 to 919.100 (1974/2004).
Indiana	NO CURRENT ACTIVITY	
Iowa	NO CURRENT ACTIVITY	
Kansas	KAN. ADMIN. REGS. §§ 40-1-34 (1981/2003).	
Kentucky	806 KY. ADMIN. REGS. 12:095 (1992/2001); 12:092 (1990).	
Louisiana		LA. REV. STAT. ANN. § 22:1892 (2009).
Maine	NO CURRENT ACTIVITY	
Maryland		MD. CODE ANN., INS. § 27-304.1 (2003) (authorizes commissioner to adopt rules about claims involving a total loss of auto); MD. CODE REGS. §§ 31.15.07.03 to 31.15.07.10 (1990/2010).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Minnesota		MINN. STAT. § 72A.201 (1967/2006); BULLETIN 2006-2 (2006).
Mississippi	NO CURRENT ACTIVITY	
Missouri	MO. CODE REGS. ANN. tit. 20, §§ 100-1.010 to 100-1.300 (1974/2011).	MO. CODE REGS. ANN. tit. 20, § 300-1.100 (2008).
Montana	NO CURRENT ACTIVITY	
Nebraska	210 NEB. ADMIN. CODE § 60 (1992/1994).	
Nevada	NEV. ADMIN. CODE §§ 686A.600 to 686A.680 (1980/2006).	
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. 1002.01 to 1002.21 (1982/2015).
New Jersey	N.J. ADMIN. CODE §§ 11:2-17.1 to 11:2-17.14 (1981/2013).	
New Mexico	NO CURRENT ACTIVITY	
New York	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 216.0 to 216.13 (Regulation 64) (1972/2014).	Circular Letter 2011-13 (2011).
North Carolina		11 N.C. ADMIN. CODE § 4.03919 (1979/1989); §§ 4.0418 to 4.0428 (1979).
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	OHIO ADMIN. CODE 3901:1-54 (1993/2004).	OHIO ADMIN. CODE 3901:1-60 (1994/2010) (health claims).
Oklahoma	OKLA. ADMIN. CODE §§ 365:15-3-1 to 365:15-3-9 (1989/1994).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Oregon	OR. ADMIN. R. 836-080-0205 to 836-080-0250 (1980/1992).	
Pennsylvania	31 PA. CODE §§ 146.1 to 146.10 (1978).	
Puerto Rico		P.R. RULE XLVII (1975).
Rhode Island	11-5-73 R.I. CODE R. §§ 1 to 11 (2014).	BULLETIN 2004-3 (2004).
South Carolina	NO CURRENT ACTIVITY	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		TEX. ADMIN. CODE §§ 21.201 to 21.205 (1976/1998); §§ 21.2801 to 21.2816 (2000).
Utah	UTAH ADMIN. CODE r. 590-89 (1982/1989); r. 590-190 (1999/2014); 590-192-1 to 590-192-14 (1999/2012).	UTAH ADMIN. CODE r. 590-191 (1999/2014).
Vermont	79 VT. CODE R. § 2 (1979).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	14 VA. ADMIN. CODE §§ 5-400-10 to 5-400-80 (1978).	
Washington	WASH. ADMIN. CODE 284-30-300 to 284-30-800 (1978/2013).	
West Virginia	W. VA. CODE R. §§ 114-14-1 to 114-14-10 (1981/2005).	Informational Letter 189 (2014).
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

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Proceeding Citations

Cited to the Proceedings of the NAIC

After a section was added to the Unfair Trade Practices Act defining unfair claims settlement practices, the subcommittee began work on a regulation. **1975 Proc. II 319.**

It was the consensus of the drafters working on the new regulation that the new drafts would provide a new emphasis on claims issues. **1990 Proc. II 160.**

Section 1. Authority

Section 2. Purpose

In 1988 a new subgroup was appointed to revisit the Unfair Claims Settlement Practices Regulation. Several regulators discussed the need to address the regulation in light of the emerging growth of private causes of action under the comparable state provisions and whether the actions were appropriate and beneficial to consumers in general. **1989 Proc. I 159.**

Two drafts were offered based on the existing model. The drafts were separated into one covering life and health claims and one covering property and casualty claims. The first issue of discussion was the NAIC's position regarding whether a private cause of action was intended to be created by the Unfair Trade Practices Act and the corresponding regulation. The subgroup decided no private cause of action was intended and language was added to the proposed drafts to that effect. **1989 Proc. II 204.**

The last sentence stating this was a clarification of original intent rather than a change of position was added with the technical amendments six months after adoption of the new model. **1991 Proc. IA 206.**

Section 3. Definitions

Most of the definitions adopted in the original model were incorporated in the new replacement model also. **1975 Proc. II 319.**

The provision incorporating the statutory definition by reference was added with the technical amendments in December of 1990. **1991 Proc. IA 206.**

B. A definition of claim file was added with the technical amendments. **1991 Proc. IA 206.**

C. The advisory committee expressed concern about the definition of claimant which also included his legal representative. The advisory committee interpreted this to mean the claimant's attorney or someone else authorized by law to represent the claimant. They did not interpret it, for example, to include the garage owner to whom the claimant had taken his car. The garage owner has an inherent conflict of interest with the claimant. Permitting the garage owner to negotiate claims on behalf of the claimant would increase the cost of settling claims. **1976 Proc. II 371.**

F. The model recognized the distinction between first and third party claimants by definition and application. This was supported by the advisory committee. **1976 Proc. II 372.**

Section 4. File and Record Documentation

Section 5. Misrepresentation of Policy Provisions

Section 6. Failure to Acknowledge Pertinent Communications

The chair of the advisory committee presented their objections to the time frame for responding to claimants. The model originally adopted allowed ten days for response, but the advisory committee did not feel this was long enough. Since the proposed regulation was to fit all lines of insurance and all kinds of companies with varying methods of operations, they thought 15 days was a more realistic starting point. **1976 Proc. II 370.** The provision adopted continued to include the ten-day limit. **1976 Proc. II 368.**

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Proceeding Citations

Cited to the Proceedings of the NAIC

Section 6 (cont.)

One comment received on the draft suggested that including requirements for unnecessary correspondence, unrealistic deadlines, and inflexible guidelines would ultimately result in an increase in settlement costs. **1976 Proc. II 372.**

Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

It was suggested by one commentator that claim settlement guidelines that would be appropriate for one line might not be appropriate for another. The time needed for settling an auto claim may have little bearing on that needed for an ocean marine claim. **1976 Proc. II 372.**

When drafters were preparing the new model regulation, the advisory committee reported continuing concerns where it felt the property and casualty regulation had gone too far in the particulars of claim assessment and the payment process. **1990 Proc. II 160.**

B. The NAIC Arson Task Force spoke in favor of adoption of the model regulation by the states and particularly endorsed the provision permitting extra time for investigations. There was general agreement that the model provision permitted insurers additional periods of time to conduct investigations as long as the insured is notified at a specific interval and given reasons for the need for additional time. The model usually works well in balancing the rights of insureds with the needs of insurance companies to adequately investigate claims. **1980 Proc. I 683.**

An amendment to both Subsections B and C was adopted upon the recommendation of the Arson Task Force. Adjusters had frequently complained that the model regulation did not allow enough time for investigation. The new second paragraph allowed a longer time to investigate in cases of suspected arson, supported by specific information, such as evidence of an accelerant used in the fire. The specific information must be available for insurance department review. **1980 Proc. II 933, 936.**

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

The first model adopted had specific provisions addressed to claims practices that had produced problems in the past, principally in the auto insurance field. **1976 Proc. II 370-371.**

E. A provision in the original model prohibited basing cash settlement on an amount less than what repairs would cost except in total loss situations. This was deleted in 1980 as incompatible with cost containment concerns. The language permitted the practice of a growing number of insurers to make a claim settlement offer based on the difference in value of the car from the time before the loss to a time directly after the loss in situations where they have good reason to believe the claimant would not have the car repaired. In almost all cases this difference in value would be less than the cost of repairing the damage and would frequently involve a situation where there already existed unrepaired damage. The subcommittee listed several advantages of this loss settlement technique: (1) Promotes cost containment on auto physical damage insurance; (2) The law of damages in most states supports a decrease in value concept; (3) Insured still has the option to have car repaired; (4) Procedure has indirectly encouraged repairing of vehicles. They also listed several disadvantages: (1) Determination of the amount of decrease is often difficult; (2) Offer often causes insureds to think they are being offered less than actual loss; (3) Procedure becomes unfair if arbitrary formulas used; (4) Hard to explain to claimants. **1981 Proc. I 262-263.**

A consumer representative expressed concern about the deletion. He described problems he felt exist in the “decrease in value” claims program. The subcommittee agreed to give consideration to his concerns. **1981 Proc. II 431.**

The subcommittee voted to reaffirm the deletion of the provision. Several insurers spoke and presented statements in support of the NAIC action. One said that the NAIC action did not imply endorsement of “decrease in value” loss settlement practices, but rather recognized currently approved policy provisions permitting alternate types of claims settlement. **1982 Proc. I 158-159.**

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Section 8E (cont.)

An association of insurers encouraged the subcommittee to retain the deletion. The representatives stated that courts in many jurisdictions used decrease in value as the measure of damage. To require settlement based on the cost of repair, regardless of whether repairs are made, will oftentimes result in the insured receiving a windfall. **1982 Proc. I 160.**

One regulator noted that certain consumer safeguards should be observed in connection with “decrease in value” claims settlement programs. The seven characteristics, necessary to make such programs effective were outlined:

- (1) An estimate of the decrease in value must be made by a qualified appraiser who has personally inspected the vehicle and this estimate must be given to the claimant.
- (2) The estimate of the decrease in value must be based on the value of the car prior to the loss and the value of the car after the loss.
- (3) Formulas, such as percentage of repair cost, may not be used to determine the decrease in value.
- (4) Settlements based on the decrease in value must contain an offer to pay the difference between the decrease in value settlement and the repair cost if the car is subsequently repaired within a reasonable period.
- (5) There must be complete documentation of each decrease in value claim settlement including an explanation of how both the decrease in value and repair cost were determined and a copy of this should be given to the claimant.
- (6) The decrease in value procedure should not be used in instances where vehicle damage involves safety-related equipment.
- (7) The decrease in value procedure should be used uniformly and should not discriminate against first-party or third-party claimants. **1982 Proc. I 158.**

J. A drafting note was added stating that this subsection incorporates the fundamental provisions of the NAIC's After Market Parts Regulation. **1991 Proc. IA 211.**

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

Chronological Summary of Actions

June 1976: Adopted Unfair Claims Settlement Practices Model Regulation.

June 1980: Adopted provision allowing additional time to investigate claims when arson is suspected.

December 1980: Deleted sentence that proscribed setting lower limit on settlement offers.

June 1990: Adopted new separate regulation for property and casualty claims.

December 1990: Adopted technical amendments.

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