

UNFAIR LIFE, ACCIDENT AND HEALTH 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 life, accident and health claims arising under policies or certificates issued pursuant to State law. It is not intended to cover claims involving workers' compensation 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 or imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate of any change of position.

Drafting Note: Any jurisdiction choosing 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. The NAIC has separately promulgated an Unfair Property/Casualty 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. "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured;
- C. "Claim file" means any retrievable electronic file, paper file or combination of both;
- D. "Claimant" means an insured, the beneficiary or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy;
- E. "Days" means calendar days;
- F. "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;
- 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 certificates or 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. "Proof of loss" means written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of all insureds or beneficiaries submitting the claims;
- K. "Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;
- L. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. Claims Practices

- A. Every insurer, upon receiving due notification of a claim shall, within fifteen (15) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.
- B. Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within fifteen (15) days.
- C. The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.
- D. The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.
- E. With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits.
- F. An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.
- G. If a claim remains unresolved for thirty (30) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice shall be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of 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.
- H. The insurer shall acknowledge and respond within fifteen (15) days to any written communications relating to a pending claim.
- I. When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.
- J. No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

- K. Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into.
- L. 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 policy.
- M. No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:
- (1) The insurer has in its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure, or
 - (2) The insurer has in its files clear, documented evidence that:
 - (a) The overpayment was clearly erroneous under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts;
 - (b) The error that resulted in the payment is not a mistake of the law;
 - (c) The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notified the insured within fifteen (15) days after the date the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued; and
 - (d) The notice stated clearly the nature of the error and the amount of the overpayment.
- N. 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 5. File and Record Documentation

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

- A. The insurer shall maintain claim data that are 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 shall be available for all open and closed files for the current year and the two (2) 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 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.

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

1990 Proc. II 7, 13-14, 160, 185-187 (adopted).

1991 Proc. I 9, 16, 192-193, 212-214 (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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MODEL REGULATION**

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 (1989/2004).	
American Samoa	NO CURRENT ACTIVITY	
Arizona	ARIZ. ADMIN. CODE § 20-6-801 (1981).	
Arkansas	43 ARK. CODE R. (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. 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) (adopts previous version of regulation by reference).
Kentucky	806 KY. ADMIN. REGS. 12:095 (1992/2001); 12:092 (1990).	
Louisiana	NO CURRENT ACTIVITY	
Maine	NO CURRENT ACTIVITY	
Maryland		MD. CODE REGS. 31.15.08.06 (1989/2014); MD. CODE REGS. 9.30.76.01 to 9.30.76.07 (1989/1993).
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).	
Montana	NO CURRENT ACTIVITY	
Nebraska	210 NEB. ADMIN. CODE § 60 (1992/1994); § 61 (1992/1994).	
Nevada	NEV. ADMIN. CODE §§ 686A.600 to 686A.680 (1980/2006).	
New Hampshire		N.H. CODE ADMIN. R. ANN. INS. §§ 1001.01 to 1001.11 (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).	
North Carolina		11 N.C. ADMIN. CODE § 4.0319 (1979); §§ 4.0418 to 4.0428 (1979/1989).
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) (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 (1980/2006).	
Pennsylvania	31 PA. CODE §§ 146.1 to 146.10 (1978).	
Puerto Rico		P.R. RULE XLVII (1975).
Rhode Island	R.I. CODE R. 27-73-001 to 27-73-011 (1994); 27-13-001 to 27-13-007 (2005/2006).	R.I. CODE R. 27-9.1-4 (2010/2013); BULLETIN 2004-3 (2004).
South Carolina	NO CURRENT ACTIVITY	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		21 TEX. ADMIN. CODE §§ 201 to 205 (1976/1998); §§ 21.2801 to 21.2816 (2000).
Utah	UTAH ADMIN. CODE r. 590-89 (1982/1989); r. 590-191 (1999/2008); r. 590-192 (1999/2009).	UTAH ADMIN. CODE r. 590-190 (1999).
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.**

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.**

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. **1976 Proc. II 371.**

Section 4. Claims Practices

After the drafting subgroup had prepared a separate draft for life and health claims, comments were solicited. One association representative commented that some efforts needed to be focused on recent developments regarding the Employment Retirement Income Security Act. He also stated that the group should consider the substantial case law that currently exists on when claims are due and that such decisions should be reflected in the regulation language. He requested that the group also consider current proposals on cost containment. **1990 Proc. IA 145.**

F. Before the new model was adopted, there was considerable discussion surrounding this subsection. As a result of the discussion, it was determined that this regulation was not the correct place to take up the issue of precertification. The draft provision was changed to simply refer to a penalty for noncompliance and to require clear disclosure. **1990 Proc. II 192.** The earlier draft had had a cap on the reduction and an exception where it did not apply. **1990 Proc. IA 160.**

As an alternative to the provision, the subcommittee adopted a resolution suggesting a subgroup of the Accident and Health Insurance Committee consider the issue of precertification, utilization review, and usual and customary charges and develop guidelines. **1990 Proc. II 192-193.**

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Proceeding Citations

Cited to the Proceedings of the NAIC

Section 5. File and Record Documentation

Chronological Summary of Actions

June 1976: Adopted Unfair Claims Settlement Practices Model Regulation.

June 1990: Adopted new separate regulation for life, accident and health claims.

December 1990: Adopted technical amendments.