Essential Protections in the Claims Process

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Homeowners' insurance provides protection and security, but only when it works. The protection and security that insurance policies provide is most effective—or it fails—when policyholders file claims because insurance companies' primary duty is to honor their promise of protection and security by paying claims promptly and fairly. Policyholders often are at a disadvantage in the claim process. They lack information and expertise about coverage under their policies and about the claim process and they may be financially and emotionally vulnerable after a major loss. To correct this imbalance and to make sure that insurance companies honor their promises, an Essential Protection is that insurance companies provide adequate information to policyholders about the claims process and establish and implement reasonable standards for processing, investigating, evaluating, and paying claims.

Insurance companies must provide policyholders with essential information about the claims process.

- **After a claim has been initiated, insurance companies must provide policyholders with information about the claim process and policyholder rights and, upon request, with a copy of the claim file.**

Policyholders are required to provide complete, accurate, and timely information in order to have their claims paid. Insurance companies have an obligation to assist policyholders in this process by giving them the information they need about policy terms, time limits, and other requirements for pursuing their claims, and information the companies have received or developed about the claims. Many of these obligations are defined in detail in state adoptions of the NAIC's Unfair Claims Settlement Practices Act (UCSPA) and Model Regulation.[1]

[1] E.g., UCSPA § 4.M.

Policyholders also should have full access to information relevant to their claims, including information the companies have received or developed about the claims. Insurance companies have a duty to conduct reasonable investigations and to assist policyholders in filing and documenting claims. To ensure that this duty is met, policyholders should have access to all information developed about their claims, commonly referred to as "the claim file."

Recommended action:

States should require insurance companies to provide policyholders full information about the claim process and information developed about claims.

Recommended statutory language:

(1) The insurer shall provide to every claimant:

(a) A copy of [relevant state statutes and regulations concerning claim practices, such as the UCSPA].

(b) Forms necessary to present claims.

(c) Explanation of time limits applicable to the claim, including time limits for filing the claim and other time limits stated in the policy or by operation of law.

(d) Explanation of the claimant's rights in the event of a dispute, including mediation and appraisal.

(e) Explanation of the availability and procedures for filing a complaint with the state insurance department.

(2) The insurer shall notify every claimant that they may obtain, upon request, copies of claim-related documents. Within fifteen calendar days after receiving a request from an insured for claim-related documents, the insurer shall provide the insured with copies of all claim-related documents, except those excluded by this section.

(a) For purposes of this section, "claim-related documents" means all documents that relate to the evaluation of loss, including, but not limited to, repair and replacement estimates and bids, appraisals, scopes of loss, reports, findings, drawings, plans, valuation, measurements, calculations,

and all other information on the cause or amount of loss, covered damages, and cost of repairs. However, attorney work product and attorney-client privileged documents and documents that contain medically privileged information are excluded from the documents an insurer is required to provide pursuant to this section to a claimant.

(b) Nothing in this section shall be construed to affect existing litigation discovery rights.

Current law:

Section 4.M of the UCSPA, adopted in some version in many states, requires insurers "to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanation regarding their use." Other state laws impose similar duties to provide information about aspects of the claim process.[2]

The duty to provide a copy of the claim file on request is specifically mandated in California Insurance Code § 2071.[3] Even in states in which there is no specific statutory mandate, insurance companies are under a duty under the UCSPA and Model Regulation to provide relevant information and assistance to policyholders. Standards of reasonableness defined by courts similarly require insurance companies to be forthcoming with their policyholders.[4] In claim practices litigation the claim file is routinely available to policyholders in discovery.[5] The same information should be available to policyholders without the need to resort to litigation. Attorney work product, attorney-client privileged, and medically privileged documents are excluded, although those exclusions should be defined narrowly because "the payment or rejection of claims is a part of the regular business of an insurance company [so that] reports prepared by insurance investigators, adjusters, or attorneys before the decision is made to pay or reject a claim are thus not privileged and are discoverable."[6]

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[2] E.g., Cal. Ins. Code § 10103.

[3] A similar requirement is contained in La. Rev. Stat. Ann. § 22:41.

[4] E.g., Bowler v. Fidelity & Cas. Co. of NY, 250 A.2d 580 (N.J. 1969).

[5] See Genovese v. Provident Life & Accident Ins. Co., 74 So. 3d 1064, 1068 (Fla. 2011); Stewart v. Siciliano, 2012-Ohio-6123, ¶ 44, 985 N.E.2d 226, 234; Cedell v. Farmers Ins. Co. of Washington, 295 P.3d 239, 245 (Wash. 2013); 2-16 New Appleman Insurance Bad Faith Litigation § 16.02; 2 Law and Practice of Insurance Coverage Litigation § 17:62 (2014).

[6] Melworm v. Encompass Indem. Co., 977 N.Y.S.2d 321, 323 (App. Div. 2013).

Insurance companies must observe reasonable time limits in the claims process.

- **Policyholders should have reasonable time limits for filing claims and, in case of a dispute, for filing litigation against the insurance company.**

After a loss, policyholders need time to collect information, retain contractors and other experts, make repairs, and restore their standard of living, all while they are suffering the financial and emotional hardships caused by a loss. Insurance companies also need time to assist policyholders and to investigate and evaluate claims. These processes can take time, particularly where the losses are major or they occur after natural disasters, where many losses place extraordinary demands on insurance companies, contractors, and others. Therefore, insurance companies must provide policyholders adequate time to make sure repairs are made, claims are fully documented, and the conditions for payment in insurance policies are fully complied with. If disputes arise, policyholders may require more time to retain legal representation and to initiate litigation. Time requirements in policies and statutes of limitations should recognize these considerations while balancing the need to prevent stale claims and to allow insurance companies to appropriately reserve for potential losses. Policyholders may be unaware of time deadlines and their effect, so insurance companies should be required to give them adequate notice so that they can comply with the deadlines.

Recommended action:

States should require insurance companies to give policyholders adequate time to file claims and, in case of a dispute, to file litigation against the company.

Recommended statutory language:

> (1) Every insurance policy shall provide that failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible. Failure to give notice or file proof of loss does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure.

(2) No insurance policy shall contain any condition or agreement that requires the policyholder to file suit against the insurer, in the case of any dispute, within a period of time that is less than two years from the date of loss. Any such provision is against public policy, illegal, and void.

(3) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement in the policy or by operation of law upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than 60 days prior to the expiration date of the requirement; except, if notice of claim is first received by the insurer within that 60 days, then notice of the expiration date must be given to the claimant immediately. Failure to give such notice shall bar the insurer from asserting any time requirement as a defense to any action or from otherwise relying on the time requirement.

(4) A policyholder under a replacement cost policy shall have no less than twelve months from the date that the first payment toward the actual cash value is made in order to collect the full replacement cost of the loss, subject to the policy limit. Additional extensions of six months shall be provided to policyholders for good cause.

Current law:

The NAIC Model Regulation § 5.D., adopted in a number of states,[7] provides that "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." The language "unless the written notice is a written policy condition" has the effect of permitting insurance companies to act unreasonably simply by including a boilerplate condition in the policy, even when the failure to give notice or file a proof of loss does not prejudice their interests. Other states remove the insurance companies' ability to rely on policy language in this way, and those laws are the basis of the recommended language.[8]

All states have statutes of limitations limiting the time within which actions may be brought. Many states also have statutes that apply specifically to insurance policies, often based on the New York Standard Fire Policy (referred to in the industry as "the

[7] E.g., Ok. Admin. Code § 365:15-3-4; Ohio Admin. Code § 3901-1-54; Pa Code § 146.4; 14 Va. Admin. Code § 5-400-40.

[8] 20 Mo. Code of State Regs. 100-1.020 ; Utah Code Ann. § 31A-21-312; W. Va. Admin. Code § 114-14-4.

165 lines" for its length in the statute), that requires the inclusion in policies of a provision that actions be "commenced within twenty-four months next after inception of the loss."[9] Many states also have statutes prohibiting and making unenforceable a provision in an insurance policy that attempts to shorten the period prescribed by the statute of limitations.[10] In the absence of a statute, courts generally hold that insurance policy terms attempting to shorten the period prescribed by the statute of limitations are disfavored but they are enforceable if they are reasonable.[11] A provision is reasonable "if it provides the insurer with prompt notice of the claim, yet allows the insured sufficient time after the rejection of the claim to investigate the claim and bring the action."[12] Even if a provision is reasonable, because of the special nature of insurance contracts courts often hold that such a provision may be enforced only if the insurer can demonstrate prejudice by the delay.[13]

Replacement cost provides the cost to repair or replace without deduction for depreciation. Policies typically provide for payment of actual cash value until the policyholder completes replacement. The time requirement in the recommended statutory language is based on the California statute.[14]

Insurance companies must observe reasonable standards in the claim process.

- **Insurance companies must promptly, fairly, and objectively process, investigate, evaluate, and resolve claims.**

The basic requirement for insurance companies when handling claims is that they must act reasonably. No insurance company would be willing to advertise its policies on any other basis, and no prospective policyholder would buy a policy on any other basis. Reasonableness does not demand perfection; everyone makes mistakes, including

[9] N.Y. Ins. Law § 3404; see also Or. Rev. Stat. § 743.660; R.I. Gen. Laws § 27-5-3..
[10] E.g., Ariz. Rev. Stat. Ann. § 20-1115; La. Rev. Stat. Ann. § 22:868; Md. Code, Insurance, § 12-104; Neb. Rev. Stat. § 44-357; W. Va. Code § 33-6-14.
[11] E.g., McDonnell v. State Farm Mut. Auto Ins. Co., 299 P.3d 715 (Alaska 2013); City of Hot Springs v. Nat'l Surety Co., 531 S.W.2d 8, 10 (1975); Auto-Owners Inc. Co. v. Hughes, 943 N.E.2d 432 (Ind. App. 2011).
[12] Davis v. State Farm Fire & Cas. Co., 545 F. Supp. 370, 371-72 (D. Nev. 1982).
[13] Estes v. Alaska Guar. Ins. Co., 774 P.2d 1315 (Alaska 1989); Zuckerman v. Transamerica Ins. Co., 650 P.2d 441 (Ariz. 1982).
[14] Cal. Ins. Code § 2051.5.

insurance companies. Reasonableness does demand that insurance companies adhere to widely accepted industry standards of performance and conform to the reasonable expectations of policyholders.

Most states have adopted the NAIC's Model Unfair Claims Settlement Practices Act and the accompanying Unfair Property/Casualty Claims Settlement Model Regulation. These rules provide minimum protections for policyholders. For example, with respect to providing essential information about the claims process to policyholders, UCSPA §4.M. requires insurance companies "to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use," and Model Regulation §6.D. further provides "Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to first party claimants so that they can comply with the policy conditions and the insurer's reasonable requirements."

The UCSPA fails policyholders in one basic respect. It treats many unreasonable actions as if they were not violations of the statute, stating that insurance companies' unreasonable actions only are wrong if they are committed intentionally or as a general business practice. Actions that are unreasonable are unreasonable whether or not they have these added elements.

Recommended action:

States should adopt the National Association of Insurance Commissioner's Model Unfair Claims Settlement Practices Act and the accompanying Unfair Property/Casualty Claims Settlement Model Regulation, without the limitation that an unreasonable action is only a violation if committed intentionally or as a general business practice.

Recommended statutory language:

> (3) It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this act if:
>
> ~~A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder, or~~
>
> ~~B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.~~
>
> (4) Any of the following acts by an insurer~~, if committed in violation of Section 3,~~ constitutes an unfair claims practice.

Current law:

The standards to which insurance companies must adhere in the claims process are set by statute, administrative regulation, and common law.

The UCSPA has been adopted in nearly every state, although individual states' adoptions vary its provisions. The Model Regulation specifies in more detail the obligations imposed on insurers. Many state insurance departments have adopted these or other administrative rules as well. Some states have adopted statutes other than the UCSPA that define claims practices standards. For example, some statutes establish a broad duty to observe fair claim practices.[15]

Courts in most jurisdictions also recognize that an obligation of good faith and fair dealing is embodied in every insurance policy as if it were written into the wording of the policy.[16] The good faith obligation has been a major source of the law of claim practices, requiring the insurer to go beyond the letter of the insurance policy and to act fairly and reasonably in processing, investigating, evaluating, and paying a claim.[17]

- **Insurance companies must observe reasonable standards for determining the amount of loss.**

[15] *E.g.*, Colo. Rev. Stat. Ann. § 10-3-1115 ("A person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed"); La. Rev. Stat. Ann. § 22:1973 (2012) ("The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach."); Md. Code Ann., Ins. § 27-1001 (2012) ("'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."); Mo. Ann. Stat. § 375.296 (sanctioning refusal to pay that is "vexatious and without reasonable cause"); Wash. Rev. Code. § 48.30.010(7) (2012) ("An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant.").

[16] *E.g.*, Bowler v. Fid. & Cas. Co. of N.Y., 250 A.2d 580, 587-88 (N.J. 1969*):* "Insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer . …. In all insurance contracts, particularly where the language expressing the extent of the coverage may be deceptive to the ordinary layman, there is an implied covenant of good faith and fair dealing that the insurer will not do anything to injure the right of its policyholder to receive the benefits of his contract."

[17] See Jay M. Feinman, The Law of Insurance Claim Practices: Beyond Bad Faith, 47 Tort Trial & Ins. Prac. L. J. 693 (2012).

Often the most difficult issue in homeowners insurance claims is determining the value of the loss. This should not be an adversarial process; insurance companies are obligated to act reasonably and in the interest of their policyholders to determine the fair value of claims. This requirement is an application of the general principle that companies are required to act in good faith toward their policyholders. In particular, companies should be obligated to observe reasonable standards for determining and paying the actual cash value or the replacement cost of the claim, as applicable under the policy. In cases of total loss, actual cash value means the value of the property as determined by the application of all relevant factors; replacement cost means the cost to repair or replace the property. In cases of partial loss under a replacement cost policy, homeowners expect that their policies enable them to repair or replace the damaged property without additional cost, observing a "functional conception" of indemnity, rather than an "economic conception."[18] Under a replacement cost policy, repair or replacement often requires matching the damaged part of the property to the undamaged part to restore the property to the condition prior to loss; for example, replacing only damaged shingles on a roof fails to restore the uniform appearance.

Recommended action :

States should mandate reasonable standards for determining the value of losses.

Recommended statutory language:

(1) Under a homeowners insurance policy that requires payment of actual cash value, the measure of the actual cash value shall be determined as follows:

(a) In case of total loss to the structure, the policy limit or the fair market value of the structure, whichever is less.

(b) In case of a partial loss to the structure, or loss to its contents, the amount it would cost the insured to repair, rebuild, or replace the thing lost or injured less a fair and reasonable deduction for physical depreciation based upon its condition at the time of the loss or the policy limit, whichever is less. In case of a partial loss to the structure, a deduction for physical depreciation shall apply only to components of a structure that are normally subject to repair and replacement during the useful life of that structure.

(2) Under a homeowners insurance policy that requires payment of replacement cost,

[18] See Kenneth S. Abraham & Daniel Schwarcz, Insurance Law and Regulation 263 (6th ed. 2015).

(a) The measure of indemnity is the amount that it would cost the insured to repair, rebuild, or replace the thing lost or injured, without a deduction for physical depreciation, or the policy limit (taking into account any extended replacement or guaranteed replacement provision in the policy), whichever is less.

(b) For a loss that 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 or any other cost except for the applicable deductible.

(c) For a loss that requires repair or replacement of items or part and the repaired or replaced items or part do not match in quality, color, or size the existing items or parts, the insurer shall repair or replace with materials of like kind and quality to provide for a reasonably uniform appearance, including repair or replacement in adjoining areas. The policyholder is not required to pay for betterment or any other cost except for the applicable deductible.

(3) In the event of a total loss of the contents of an owner-occupied primary residence that was furnished at the time of loss, the insurer shall offer the policyholder a minimum of thirty percent, or a larger percent by mutual agreement of the policyholder and insurer, of the value of the contents coverage reflected in the declaration page of the homeowner's policy without requiring submittal of a written inventory of the contents. In order to receive up to the full value of the contents coverage, the policyholder may accept the offer under this paragraph and submit a written inventory as required by the insurer.

(4) If the policyholder receives the depreciated value of contents insured under a policy, the insurer must make available to the insured the methodology used for determining the depreciated value of the insured contents.

Current law:

Actual cash value is generally determined according to a "broad evidence" rule, under which any relevant factor is considered in determining the value of a loss.[19] Sometimes this translates to replacement cost less depreciation.[20] The deduction for depreciation only applies to components "that are normally subject to repair and replacement during

[19] The leading case is McAnarney v. Newark Fire Ins. Co., 159 N.E. 902 (N.Y. 1928). See Robert H. Jerry, II & Douglas R. Richmond, Understanding Insurance Law 638 (5th ed. 2012).
[20] Cal. Ins. Code § 2051.

the useful life of that structure."[21] Even then, a number of states have recognized that in cases of partial loss policyholders seek functional indemnity—for example, having a roof repaired without additional expense to the homeowner.[22]

Replacement cost provides the cost to repair or replace without deduction for depreciation. Policies typically provide for payment of actual cash value until the policyholder completes replacement. The procedural requirement in the recommended statutory language is based on the Colorado statute.[23]

Matching to restore a uniform appearance is required by the National Association of Insurance Commissioners' Unfair Property/Casualty Claims Settlement Practices Model Regulation (MDL-902, 1997). Many states have adopted statutes or administrative rules based on the Model Regulation.[24] Other states have adopted the matching principle by court decision,[25] although not all states agree.[26]

- **Policyholders should have access to efficient, effective means of dispute resolution.**

When a loss occurs, homeowners need to receive the benefits of their insurance policies quickly and fully in order to repair their property and rebuilding their lives. Therefore, when disputes concerning claims arise between policyholders and their insurance companies, policyholders need efficient, effective, and expeditious means of resolving the disputes. Litigation ultimately may be necessary but it is a last resort for

[21] Id.
[22] Sperling v Liberty Mut. Ins. Co., 281 So.2d 297 (Fla. 1973); Thomas v. American Family Mut. Ins. Co., 666 P.2d 676 (Kan. 1983).
[23] Colo. Rev. Stat. §10–4–110.8 (11).
[24] Cal. Code of Regs., tit. 10, § 2695.9; Conn. Gen. Stat. § 38a-316e (2014); Fla. Stat. Ann. § 626.9744; Iowa Admin. Code § 191-15.44 (507B); Ky. Admin. Regs. tit. 806, ch. 12 § 095; Neb. Admin. R. & Regs. tit. 210, Ch. 60, § 010; Ohio Admin. Code § 3901-1-54; R.I. Admin. Code § 11-5-73:9; Utah Admin. Code R590.190-13(1)(b).
[25] E.g., Nat'l Presbyterian Church, Inc. v. GuideOne Mut. Ins. Co., 82 F. Supp. 3d 55, 56-57 (D.D.C. 2015); Cedar Bluff Townhome Condo. Ass'n, Inc. v. Am. Family Mut. Ins. Co., No. A13-0124, 2013 WL 6223454, at *1 (Minn. Ct. App. Dec. 2, 2013), aff'd, 857 N.W.2d 290 (Minn. 2014); Trout Brook S. Condo. Ass'n v. Harleysville Worcester Ins. Co., 995 F. Supp. 2d 1035, 1042 (D. Minn. 2014); Alessi v. Mid-Century Ins. Co., Inc., 464 S.W.3d 529, 530 (Mo. Ct. App. 2015).
[26] E.g., Graffeo v. State Farm Fire & Cas., Inc., 628 So. 2d 790 (Ala. Civ. App. 1993); Woods Apartments, LLC v. U.S. Fire Ins. Co., No. 3:11-CV-00041-H, 2013 WL 3929706, at *1 (W.D. Ky. July 29, 2013); Enwereji v. State Farm Fire & Cas. Co., No. 10-CV-4967, 2011 WL 3240866, at *1 (E.D. Pa. July 28, 2011).

policyholders because it takes time, delaying the process of recovery, and it is financially and emotionally draining. Two alternatives to litigation that can be effective for homeowners are mediation and appraisal. Mediation provides an informal but structured forum in which policyholders and insurers can meet with the aid of a qualified mediator to discuss and attempt to resolve disputes. Appraisal provides a process by which neutral parties can assess loss and determine the costs of repair. Each needs to be well-designed and supported to meet policyholders' needs.

United Policyholders has prepared Best Practices for Post-Disaster Insurance Claim Mediation Programs, available on the UP website. Those Best Practices also can be used as a guide for the implementation of a mediation program for other property insurance disputes. Essential elements of an effective mediation program include the following:

- Policyholders should be fully informed about their right to mediation and should be provided advice and counseling about the process.
- Policyholders should be able to request non-binding mediation in which insurance companies are required to participate.
- Mediators should be qualified in both the mediation process and property insurance issues.
- The costs of mediation should be borne by the insurance companies.

Despite the presence of alternatives to litigation such as mediation and appraisal, litigation may be the only means to resolve a dispute or for policyholders to obtain the benefits their insurance companies promised to them. Companies sometimes attempt to prevent policyholders from having their day in court through forced arbitration clauses in insurance policies. Arbitration can be a fair and efficient means of dispute resolution if both parties agree to arbitrate a claim after a dispute has arisen, but it should not be imposed on policyholders by a policy term that is usually hidden in boilerplate or the consequences of which are not well understood. Arbitration often fails to protect policyholders because discovery is limited, arbitrators can be more favorable to insurance companies, arbitration rulings cannot be reviewed even for errors of law or fact, and the rulings are private so they do not serve the public function of clarifying the law.

Recommended action:

States should adopt a mediation program for property insurance disputes.

States should adopt an appraisal process that provides neutral parties to assess all relevant aspects of a claim.

States should prohibit the enforcement of pre-dispute forced arbitration provisions.

Recommended statutory language:

> [Appraisal: In addition to specifying procedures for appraisal such as are included in the New York Standard Fire Insurance Policy,[27] which has been used as a model in other states, the statute should contain the following language defining the scope of appraisal.]
>
> An appraisal shall determine the actual cash value, the replacement cost, the extent of the loss or damage, and the amount of the loss or damage, which shall be determined as specified in the policy.
>
> [Arbitration:]
>
> No insurance policy shall contain any condition, stipulation or agreement depriving the courts of this state of the jurisdiction of an action against the insurer by providing for arbitration or otherwise. Any such condition, stipulation, or agreement shall be void and shall not preclude any party or beneficiary under the insurance policy from instituting suit or legal action on the contract at any time, and the compliance with the clause or provision shall not be a condition precedent to the right to bring or recover in the action.
>
> [States that have adopted a version of the Uniform Arbitration Act or similar legislation also should include a provision like the following in that statute:]
>
> This part shall not apply to any contract of insurance; provided, however, that nothing in this paragraph shall impair or prohibit the enforcement of or invalidate an arbitration clause or provision in a contract between insurance companies.

Current law:

Some states provide for mediation of insurance disputes, either in general or for claims arising after natural disasters.[28]

Homeowner' policies typically provide for appraisal and some states require that it be available. Courts divide on the issues appropriate for appraisal—whether, for example, appraisal is limited to determining the amount of damage and cost of repair or whether

[27] , N.Y. Ins. Law § 3404.

[28] *E.g.*, Fla. Stat. Ann. § 627.7015.

appraisal also may determine the scope of loss and issues of causation.[29] Appraisal is more effective if it includes both types of issues, as reflected in the recommended statutory language.[30] Appraisal does not address issues of interpretation of insurance policy language that determines coverage, which properly are for the courts.

More than a dozen states prohibit enforcement of arbitration clauses in insurance policies by statute or regulation[31] and another ten states restrict the use of arbitration.[32] The Federal Arbitration Act as interpreted by the U.S. Supreme Court generally preempts state law that bars or limits arbitration, but state statutes should be upheld based on the reverse preemption provision of the McCarren-Ferguson Act under which states are permitted to regulate the business of insurance.[33]

- **Insurance companies must not unreasonably pressure policyholders to settle claims.**

Policyholders typically are at a significant disadvantage in the claim process because they need the payments from their insurance companies to repair or rebuild. If insurance companies delay payments or extend the process, policyholders may be forced to give up their justified claims or settle them for less than they are worth. An Essential Protection requires companies to pay what they acknowledge they owe, even if other portions of claims are disputed, and not use the threat of litigation to coerce policyholders.

Recommended action:

States should adopt requirements that insurance companies pay claims promptly, including undisputed amounts of claims where other amounts are in dispute.

Recommended statutory language:

[29] See Couch on Insurance §§ 209.8-9, 210.42 (3rd ed.).
[30] Based on McKinney's Consol. Laws of N.Y. § 3408(c).
[31] *E.g.*, Ark. Code Ann. § 16-108-201; Haw. Rev. Stat. § 431:10-221; Kan. Stat. Ann. § 5-401.
[32] *E.g.*, Utah Admin. Code R590-122; Wyo. Rules Ins. Gen. ch. 23, sec. 9.
[33] *E.g.*, Standard Sec. Life Ins. Co. v. West, 127 F. Supp.2d 1064 (W.D. Mo. 2001); Friday v. Trinity Universal of Kansas, 939 P.2d 869 (1997).

[States should include in their adoption of section 4 of the UCSPA or equivalent the following language; variations in state adoptions would require appropriate changes.]:

Any of the following acts of an insurer constitute an unfair claims practice:

(1) Failing to promptly settle or pay claims where liability has become reasonably clear under one portion of the insurance policy.

(2) Failing to promptly pay undisputed amounts of partial or full benefits owed after an insurer determines the amounts of partial or full benefits and agrees to coverage of the undisputed amounts.

(3) Making known to insureds a policy of appealing from mediation, appraisal, or arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises less than the amount awarded in mediation, appraisal, or arbitration.[34]

[States also should adopt affirmative time limits for the payment of claims and language requiring partial payment as follows]:

In any case where there is no dispute as to one or more elements of the claim, an insurer shall pay the portion or portions not in dispute notwithstanding the existence of the dispute without prejudice to either party.

Current law:

Many states have adopted one or more of these provisions, either by statute or regulation, to provide further definition to the UCSPA's general prohibition on insurance companies' actions in "Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies" and "Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear."[35] Most states also specify time limits for responding to and paying claims. As to section (1), some states use the recommended language;[36] others state the duty in the affirmative and refer to an undisputed claim.[37] As to section (2), language differs[38] and the requirement sometimes

[34] This language would amend Section 4 of the UCSPA. Variations in state adoptions would require appropriate changes.

[35] UCSPA §§ 4.C.-D.

[36] E.g., Vernon's Ann. Mo. Stat. § 375.1007(15); S.D. Codified L. § 58-33-67(4); Utah Admin. Code R590-190.

[37] "In any case involving a claim in which there is a dispute over any portion of the insurance policy coverage, payment for the portion or portions not in dispute must be made

has been imposed by court decision.[39]As to section (3), the suggested language is commonly used.[40]

Policyholders must have effective remedies if insurance companies act unreasonably.

- **If an insurance company acts unreasonably, a policyholder should be able to sue and recover damages, including attorneys' fees, that are adequate to fully compensate for its loss and to deter wrongful behavior by insurance companies.**

The protections that policyholders have are only as good as the means available to enforce them. Every state recognizes that policyholders can sue their insurance companies for failing to pay what is owed under insurance policies; these are ordinary breach of contract suits. Where insurance companies act unreasonably, the amounts owed under the policies are inadequate either to compensate policyholders for their losses or to deters companies from unreasonable conduct in the future. When insurance claims are improperly delayed or denied, policyholders may suffer other financial losses and emotional harm. For example, homeowners who do not receive prompt payment may have additional expenses due to being out of their homes and may suffer extreme aggravation and distress. If policyholders have to pay attorneys and incur other litigation expenses to get what they are entitled to, they are never fully compensated for their losses. Moreover, if insurance companies only have to pay what they originally owed under their policies even where the act wrongfully, they have much less incentive to pay claims promptly and fairly; delaying claims increases their investment income and denying claims adds directly to their bottom line.

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notwithstanding the existence of the dispute where payment can be made without prejudice to any interested party." Nev. Admin. Code § 686A.675; W. Va. Code R. 114-14-6.

[38] E.g., Fla. Stat. Ann. § 626.9541(1)(i)(4); 806 Ky. Admin. Regs. 12:095 § 6(6); Nev. Admin. Code § 686A.675(7); N.H. Code Admin. R. Ann. Ins 1002.07.

[39] E.g., Chester v. State Farm Ins. Co., 117 Idaho 538, 541, 789 P.2d 534, 538 (Idaho Ct. App. 1990); Castellano v. State Farm Mut. Ins. Co., 2013 WL 5519596 (Ill. App. 2103); Dupree v. Lafayette Ins. Co., 51 So. 3d 673 (La. 2010).

[40] See, e.g., Ind. Code § 27-4-1-4.5(11); Mich. Comp. Laws Ann. § 500.2026(1)(k); N.H. Rev. Stat. § 417:4(XV)(6); N.J. Stat. Ann. § 17B:30-13.1.

Recommended action:

States should require insurance companies to act reasonably in processing, investigating, evaluating, and resolving claims and should give policyholders the right to sue for appropriate damages if the companies do not do so.

Recommended statutory language:

(1) An insured may bring a civil action against an insurer when such person is damaged:

(a) when its claim for payment of benefits has been unreasonably delayed or denied, or

(b) by a violation of the [state's Unfair Claims Settlement Practices Act or rules adopted by the Insurance Commissioner to implement that statute], notwithstanding that the insurer did not violate any applicable provision with enough frequency as to indicate a general business practice.

Alternative 2-A:

(2) In any action under this statute, the insured shall recover from the insurer

(a) actual damages caused by the insurer's misconduct;

(b) reasonable attorneys' fees, filing fees, and reasonable costs of suit;

(c) interest on the amount of the claim from the date the claim was made by the insured; and

(d) threefold the damages sustained.

Alternative 2-B:

(2) In any action under this statute, the insured shall recover from the insurer

(a) actual damages caused by the insurer's misconduct;

(b) reasonable attorneys' fees, filing fees, and reasonable costs of suit; and

(c) interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 10%.

Current law:

Most states provide a remedy for violation of claim practices standards, sometimes referred to as "bad faith." In a majority of those states, insurance companies are liable if they act unreasonably and if they know they have done so or acted in "reckless

disregard" of the lack of a reasonable basis for their action.[41] Other states only require unreasonable behavior for the cause of action.[42]

In cases of late payment or nonpayment, statutes in some states provide remedies beyond payment of the amount already owed under the policy. These remedies include interest at a rate higher than the statutory rate,[43] other penalties greater than the value of the claim,[44] and attorney's fees.[45]

In the absence of statutes, courts in bad faith cases often follow ordinary tort damage rules to permit the recovery of all economic losses that flow from the insurance company's breach. These damages may include the cost of obtaining the amount properly due under the policy, including attorney's fees and litigation costs,[46]and emotional distress in appropriate cases.[47] In appropriate cases, punitive damages may be awarded as well.[48]

United Policyholders has published a fifty-state survey of this body of law, available at the UP website, which should be consulted for more detail.[49]

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[41] The leading case is Anderson v. Continental Insurance Co., 271 N.W.2d 368 (Wis. 1978).
[42] The leading case is Gruenberg v. Aetna Insurance Co., 510 P.2d 1032 (Cal. 1973).
[43] *E.g.*, Me. Rev. Stat. Ann. Ins. 24-A, § 2436 (1-1/2% per month); Md. Code Ann., Cts. & Jud. Proc. § 3-1701 (10% per annum); 36 Okla. Stat. Ann. § 3629 (15% per year); 42 Pa. Cons. Stat. Ann. § 8371 (prime rate plus 3%).
[44] *E.g.*, Ga. Code Ann. § 33-4-6 (2012) (additional damages up to 50% of the loss or $5,000, whichever is greater, plus attorney's fees); La. Stat. Ann.-R.S. § 22:1821 (2012) (double payment plus attorney's fees in health and accident insurance); La. Stat. Ann.-R.S. § 22:1892(B)(1) (2012) (penalty of greater of 50% of amount owed or $1,000 in other insurance); Rev. Code Wash § 48.30.015(2) (2012) (up to three times actual damages, plus attorney's fees). Other statutes authorize punitive damages (42 Pa. Cons. Stat. Ann. § 8371) or exemplary damages (Mont. Code Ann. § 33-18-242) as determined by the trier of fact.
[45] *E.g.*, Ark. Code Ann. § 23-79-208; Colo. Rev. Stat. Ann. § 10-3-1115 (2012); Fla. Sta. Ann. § 627.428; Md. Code Ann., Cts. & Jud. Proc. § 3-1701 (2012); New Mex. Stat. Ann. § 39-2-1; 42 Pa. Cons. Stat. Ann. § 8371 (2012).
[46] *E.g.*, Brandt v. Superior Court (Standard Ins. Co.), 693 P.2d 796, 798-99 (Cal. 1985); White v. W. Title Ins. Co., 710 P.2d 309, 320 (Cal. 1985).
[47] *E.g.*, Gourley v. State Farm Mut. Auto. Ins. Co., 822 P.2d 374, 378 (Cal. 1991); Farr v. Transamerica Occidental Life Ins. Co., 699 P.2d 376, 382 (Ariz. Ct. App. 1984).
[48] *E.g.*, Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 379 (Wis. 1978); Best Place, Inc. v. Penn Am. Ins. Co., 920 P.2d 334, 347-48 (Haw. 1996).
[49] See also Jay M. Feinman, The Law of Insurance Claim Practices; Beyond Bad Faith, 47 Tort Trial & Ins. Prac. L.J. 693 (2012).

About Essential Protections for Policyholders

Essential Protections for Policyholders is a project of the Rutgers Center for Risk and Responsibility in cooperation with United Policyholders.

The Rutgers Center for Risk and Responsibility at Rutgers Law School explores the ways in which society makes choices about risk, its proper allocation, and compensation for the harm caused when risks materialize.

United Policyholders is a non-profit 501(c)(3) organization whose mission is to be a trustworthy and useful information resource and a respected voice for consumers of all types of insurance in all fifty states.

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