SB 2245

Measure Title:	RELATING TO INSURANCE.
Report Title:	Insurance; Motor Vehicle Insurance; First Party Claims; Prompt Payment
Description:	Requires an insurer in a first party insurance claim to pay the claimant a fair amount within thirty days of a demand for payment of insurance benefits.
Companion:	HB2403
Package:	None
Current Referral:	CPN
Introducer(s):	SHIMABUKURO, Baker

NEIL ABERCROMBIE
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TO THE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Wednesday, February 5, 2014
9 a.m.

TESTIMONY ON SENATE BILL NO. 2245 – RELATING TO INSURANCE.

TO THE HONORABLE ROSALYN H. BAKER, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department opposes this bill, and submits the following comments:

This bill requires an insurer to pay its policyholder the undisputed claim amount within 30 days of demand.

This bill is unnecessary because these consumer protection provisions are already codified in HRS §431:13-103(a)(11)(F), which identifies the conduct as an unfair claim settlement practice: "[f]ailing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute."

We thank the Committee for the opportunity to present testimony on this matter.

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Hawaii State Legislature
Senate Committee on Commerce and Consumer Protection
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

February 3, 2014

Filed via electronic testimony submission system

RE: SB 2245, Insurance; Motor Vehicle Insurance; First Party Claims; Prompt Payment - NAMIC's Written Testimony for Committee Hearing

Dear Senator Rosalyn H. Baker, Chair; Senator Brian T. Taniguchi, Vice Chair; and members of the Senate Committee on Commerce and Consumer Protection:

Thank you for providing the National Association of Mutual Insurance Companies (NAMIC) an opportunity to submit written testimony to your committee for the February 5, 2014, public hearing. Unfortunately, I will not be able to attend the public hearing, because of a previously scheduled professional obligation.

NAMIC is the largest property/casualty insurance trade association in the country, serving regional and local mutual insurance companies on main streets across America as well as many of the country's largest national insurers.

The 1,400 NAMIC member companies serve more than 135 million auto, home and business policyholders and write more than $196 billion in annual premiums, accounting for 50 percent of the automobile/homeowners market and 31 percent of the business insurance market. NAMIC has 69 members who write property/casualty and workers' compensation insurance in the State of Hawaii, which represents 30% of the insurance marketplace.

Through our advocacy programs we promote public policy solutions that benefit NAMIC companies and the consumers we serve. Our educational programs enable us to become better leaders in our companies and the insurance industry for the benefit of our policyholders.

Thank you for your time and consideration. Please feel free to contact me at 303.907.0587 or at crataj@namic.org, if you would like to discuss NAMIC's written testimony.

NAMIC's members appreciate the importance of providing their policyholders with a timely resolution of their insurance claim, and policyholders are quite satisfied with the timeliness and comprehensiveness of the claims adjusting services provided to them by their insurance

company. NAMIC is concerned that this proposed legislation is, not only an unnecessary fix to a non-existent problem, but also a legislative proposal rife with potential adverse unintended consequences for insurance policyholders.

NAMIC respectfully submits the following concerns with SB 2245:

1) The proposed legislation is a "solution in search of a problem"

NAMIC has not seen any Department of Commerce and Consumer Affairs Division of Insurance data to support the contention that there is any type of systemic problem with insurers not settling first-party claims in a timely manner.

Insurers want and need to retain the insurance business of their policyholders, so they do everything they reasonable can to provide their policyholders with fast, fair, and friendly claims services. Unfortunately, since insurance claims are not all identical, some take more time to settle than others, based upon a multitude of legitimate factors that need to be taken into consideration to provide the consumer with the contractual rights they are entitled to pursuant to the insurance policy. SB 2245 would subject claims adjusting to a "one size fits all" time-table that is impractical, unworkable, and detrimental to the policyholder.

Additionally, NAMIC believes that the proposed legislation is entirely unnecessary because insurance consumers already have appropriate legal and regulatory protections in place to make sure that they are promptly paid as soon as liability and damages are reasonably determined. Specifically, the Hawaii's Unfair Claim Settlement Practices Act lists as an unfair practice, the failure to offer payment within thirty days of affirmation of liability if the amount of the claim has been determined and it is not in dispute. (Haw. Rev. Stat. 431:13-103 (a)(11)(F).

2) The proposed legislation will actually harm not help insurance policyholders

SB 2245 states, "the insurer shall pay to the claimant an amount the insurer deems fair within thirty days of a demand for payment of insurance benefits . . ."

NAMIC is concerned that SB 2245 will actually delay the resolution of first-party insurance claims, by refocusing legal attention upon the insurer's initial and partial settlement payment as opposed to the insurer's final and full settlement payment of the insurance claim.

Specifically, the proposed legislation will impose a bright-line legal deadline for payment that may not be consistent with the needs of the policyholder, who benefits from the insurer being able to conduct a thorough and comprehensive evaluation of the fact of the claim, which may take more than thirty days in certain cases. For example, if the policyholder has a property damage claim where another driver is arguably at-fault and the policyholder would prefer to have the at-fault driver's insurer pay for the damages to avoid having to pay their deductible as part of their first-party insurance claim, a liability dispute may not be resolved within thirty days, especially if the dispute has to be submitted to intercompany arbitration for a liability determination.

Moreover, certain damages, like UM/UIM damages, require the resolution of an underlying liability claim against an at-fault third-party before the insurer can settle them. The proposed legislation doesn't take these type of situations into consideration and requires a claims settlement payment from the insurer that is impractical and potentially impossible to calculate within thirty days of the demand. Additionally, certain types of damages (the pain and suffering portion of a UM/UIM bodily injury claim) are not conducive, based upon their legal and medical nature, to a damages valuation within thirty days of a settlement demand.

The proposed legislation could force insurers to have to "guestimate" on damages in order to comply with the unrealistic thirty days settlement payment deadline. The legal and practical application implications of this proposed settlement mandate is not in the best interest of the insurance policyholder and could adversely impact the policyholder in his/her underlying liability claim against the at-fault party.

Insurance policyholders are contractually entitled to and benefit from claims settlement practices that promote fair and accurate settlements, not rushed settlements. SB 2245 misplaces legal emphasis upon speed as opposed to accuracy in the claims settlement process.

3) SB 2245 will lead to unnecessary litigation.

NAMIC is concerned that the proposed legislation is likely to lead to unnecessary and costly litigation that will act as an insurance rates cost-driver to the detriment of insurance consumers.

The language of the bill uses a number of terms and phrases that are subjective in nature and prone to disagreement in interpretation, which will lead to needless litigation.

SB 2245 states that, "the insurer shall pay to the claimant an amount the insurer deems *fair* within thirty days of a *demand for payment* of insurance benefits . . ." (Emphasis added).

Specifically, the language of the bill suggests that the insurer decides what amount is fair, but is that determination legally conclusive, or could the insurer be legally challenged by the policyholder if the policyholder has a different definition of "fair"? Reasonable minds can easily disagree on what is "fair", especially when the valuation pertains to a subjective issue, like pain and suffering damages in a UM/UIM claim.

Additionally, what is meant by a "demand for payment"? Does it contemplate the submission of a formal settlement demand by the policyholder or would some loose and informal communication about damages between the policyholder and the insurer constitute a settlement demand? If a mere oral communication triggers the thirty day deadline, an insurer could be found in violation of the statute without ever actually knowing that the policyholder intended the informal oral communication to constitute a demand for payment. This type of statutory vagueness creates a fecund field for litigation, particularly when considered in light of the statutory provision in SB 2245 that states, "this section shall not affect any recourse the first party claimant may have against the insurer." NAMIC is concerned that SB 2245 is <u>really</u> all about creating potential for bad faith litigation over vague terminology and an unworkable payment deadline.

4) The proposed legislation interferes with the contractual rights of the insurer and policyholder.

SB 2245 states, "If *after the payment*, the fair value of the claim is still in dispute between the insurer and the claimant, the matter may be resolved according to the provisions in the motor vehicle insurance policy." (Emphasis added).

NAMIC is concerned that the aforementioned language improperly interferes with the contractual rights of the parties, because it restricts application of the contractual rights of the parties to a time after the thirty day settlement payment. The bill specifically states that the "matter may be resolved according to the provisions in the motor vehicle insurance policy" after the payment. Insuring agreements are in full force and effect upon execution and are legally operative before, during and after the filing of an insurance claim, so the terms of the policy are legally binding upon the parties throughout the professional relationship. SB 2245 would effectuate an improper and unjustifiable interference with the contractual rights of the parties to the insurance contract, which raises constitutional law legal concerns for NAMIC.

In closing, NAMIC respectfully requests that the Senate Committee on Commerce and Consumer Protection "**vote no**" on SB 2245, because the proposed legislation will only facilitate and encourage claims settlement conflict, not claims settlement resolutions, and will be harmful, not helpful to insurance policyholders.

Respectfully,

Christian John Rataj, Esq.
NAMIC Senior Director – State Affairs, Western Region

HAWAII INSURERS COUNCIL
A trade association of property and casualty insurance companies

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Alison Powers
Executive Director

TESTIMONY OF MICHAEL TANOUE

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Sen. Rosalyn H. Baker, Chair
Sen. Brian T. Taniguchi, Vice Chair

Wednesday, February 5, 2014
9:00 a.m.

SB 2245

Chair Baker, Vice Chair Taniguchi, and members of the Committee on Commerce and Consumer Protection, my name is Michael Tanoue, counsel for the Hawaii Insurers Council, a non-profit trade association of property and casualty insurance companies licensed to do business in Hawaii. Member companies underwrite approximately one third of all property and casualty insurance premiums in the state.

The Hawaii Insurers Council **opposes** SB 2245.

SB 2245 would require an automobile insurer to pay to a first-party claimant an amount the insurer considers to be "fair" within thirty days of a demand for payment of insurance benefits.

In the context of automobile physical damage coverage – including collision and comprehensive (or other than collision) coverage – a mandatory thirty-day deadline for payment is unnecessary. In a vast majority of such first-party insurance claims, the claim for physical damage is investigated, adjusted, and paid within a thirty-day period. In addition, most automobile insurance policies include rental coverage for a specified period of time that the vehicle is being repaired. Thus, the insured's interests during the thirty-day period are already protected.

In the context of uninsured motorists (UM) or underinsured motorist (UIM) coverage, the Bill imposes unrealistic and unreasonable requirements on insurers.

In most UM and UIM claims, the insurer does not receive sufficient information about the claimant's injuries allegedly sustained in the accident, the claimant's pre-accident history, if any, and other damages information within the thirty-day period after a demand for payment. Frequently, the demand for payment is devoid of any information or may contain only incomplete information. Because claimants have protected privacy interests in their medical, financial, and employment records, insurers investigating a UM or UIM claim first need to obtain appropriate signed authorizations from claimants and/or stipulated protective agreements before health care providers and employers release the information necessary for insurers to evaluate a claim. Even when authorizations and protective agreements are obtained, medical providers and employers require time to research, collect, copy and transmit documents in their possession.

The word "fair" and the mandate to pay a "fair" amount in the Bill are either extraneous or too simplistic. On the one hand, if a "fair" amount is objectively discernible, then the claimant and the insurer should be able to settle the UM or UIM claim even without the Bill. On the other hand, the reality is that the word "fair" is far from objective and is dependent upon multiple factors – liability issues, pre-existing conditions, objective versus subjective complaints of pain, diagnoses, prognoses, the witness potential of the claimant, and the UM or UIM insurance limits, just to name a few. Thus, a legislative mandate that insurers pay a "fair" amount ignores the difficult and time-consuming tasks required of insurers when they evaluate UM and UIM claims.

Based on the foregoing, the Hawaii Insurers Counsel opposes SB 2245 and requests that it be held. Thank you for the opportunity to testify.

PCI

Property Casualty Insurers
Association of America

To: The Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection

From: Mark Sektnan, Vice President

Re: **SB 2245 – Relating to Insurance**
PCI Position: Oppose

Date: Wednesday, February 05, 2014
9:00 a.m., Conference Room 229

Aloha Chair Baker, Vice Chair Taniguchi and Members of the Committee:

The Property Casualty Insurers Association of America (PCI) is **opposed to SB 2245** which would set a new, less clear, threshold for the payment of first party medical claims.
PCI is a national trade association that represents over 1,000 property and casualty insurance companies. In Hawaii, PCI member companies write approximately 34.6 percent of all property casualty insurance written in Hawaii. PCI member companies write 42.2 percent of all personal automobile insurance, 43.5 percent of all commercial automobile insurance and 58.9 percent of the workers' compensation insurance in Hawaii.

Although paying claims quickly is a reasonable goal for legislation, this bill seems to ignore both existing law and the challenges insurers face in settling claims. Current law (431:10C-304 3(A) already states *"Payment of PIP benefits shall be made within 30 days after the insurer has received reasonable proof of fact..."* This bill seems to be changing the standard to one that is more unclear and could create the situation where an insured or their representative could make the argument that an insurance carrier now has the obligation to pay what is fair based upon a received billing with no supporting information at all. The insurer needs supporting information such as treatment notes, medical records, or narrative reports to substantiate the claim. This bill appears to prevent the insurer from performing their duty to investigate the medical necessity, reasonableness, and appropriateness of the billed treatment and also challenges the insurer's ability to combat fraud.

While the vast majority of auto property damage claims can be paid in 30 days because the damage is relatively easy to determine, injury claims, including uninsured motorist and underinsured motorist claims (UM and UIM), are a different story. The full extent of injuries is rarely known within thirty days. In many cases, it is routine not to get any information about bills and injuries for months for those claimants represented by attorneys. The insurer cannot

take any action without information and we question whether this new standard of "fair" will open up insurance companies to bad faith lawsuits.

What happens if the insurer responds timely to the UM demand with an offer which is rejected by the claimant? Under the typical Hawaii UM coverage contract language, an arbitration process occurs. If the arbitrator's award is significantly higher than the insurer's offer, can the claimant claim bad faith since the offer was not "fair" based on the objective conclusion drawn by the arbitrator? The same could apply to a court decision.

Existing law already ensures that insurers pay promptly. This bill could result in more confusion and litigation and actually slow down the final settlement of cases.

For these reasons, PCI asks the committee to hold this bill in committee.

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) IN SUPPORT OF S.B. 2245

Wednesday, February 5, 2014

9:00 am

To: Chairperson Rosalyn Baker and Members of the Senate Committee on Commerce and Consumer Protection:

My name is Bob Toyofuku and I am presenting testimony on behalf of the Hawaii Association for Justice (HAJ) in SUPPORT of S.B. No. 2245.

This bill protects consumers by making sure that insurance companies pay benefits that an insurance company admits are owed to the consumer.

Consumers pay premiums to insurance companies for financial protection in the event that they are injured in an accident. Of course, the consumer must pay the insurance company's premium on time or their insurance coverage, and the financial protection the policy provides, is cancelled. All that the consumer receives in return is a promise from the insurance company that it will fairly pay the consumer's claim in the event of an accident.

Unfortunately, with increasing regularity, some insurance companies refuse to pay customers' benefits that are admittedly owed so that the insurance company can financially leverage the consumer into abandoning disputed claims. By way of example, an insurance customer is injured and makes a claim for $100 of benefits. The insurance determines that the customer is obviously due $60 but disputes that the customer is due the additional $40 in benefits. Instead of paying the $60 that is admittedly due, the insurance company refuses to pay the $60 unless the consumer agrees to give up their claim for the remaining $40 in benefits.

By definition, consumers are making these claims after an accident. Many times, the consumer is unable to pay rent, buy food or is somehow unable to make ends meet. An insurance company that refuses to pay benefits that are admittedly owed forces the financially

strapped consumer to give up the remainder of their claim and accept the insurance company's offer.

Some insurance companies take a much fairer and appropriate approach. When the insurance company determines that the consumer is obviously due the $60, the $60 is paid to the consumer and the disputed $40 claim is submitted to arbitration. This allows the consumer to obtain the financial protection that is undisputed without being forced to give up the remainder of their claim.

This bill would make clear that any insurance company who sells insurance to Hawaii's consumers must make payment within 30 days of all benefits which the insurance company admits are owed to the consumer. This bill promotes fairness and protects consumers from insurance companies that would try to financially intimidate consumers into accepting any offer made by the insurance company.

Thank you for the opportunity to present this testimony and feel free to contact me if you have any questions on this issue.

Testimony of
Gary M. Slovin / Mihoko E. Ito
on behalf of
USAA

DATE: February 3, 2014

TO: Senator Rosalyn Baker
Chair, Committee on Commerce and Consumer Protection
Submitted Via CPNTestimony@capitol.hawaii.gov

RE: **S.B. 2245 – Relating to Insurance**
Hearing Date: Wednesday February 5, 2014 at 9:00am
Conference Room: 229

Dear Chair Baker and Members of the Committee:

We submit this testimony in **opposition** to S.B. 2245 on behalf of USAA, a diversified financial services company. USAA is the leading provider of competitively priced financial planning, insurance, investments, and banking products to members of the U.S. military and their families. USAA has over 82,000 members in Hawaii, the vast majority of which are military-based members.

USAA opposes S.B. 2245, which requires an insurer in a first party insurance claim to pay the claimant a fair amount within thirty days of a demand for payment of insurance benefits.

Hawaii's Unfair Claims Settlement Practices Act (HRS 431:13-103(a)(11)(F)) already requires offer of payment within 30 days if a claim is determined and not in dispute. The only situations to which this bill would not apply are complex cases where 30 days is insufficient time to complete investigations. Oftentimes, in complicated situations like multi-vehicle accidents or accidents where severe injuries limit the parties' availability, 30 days is not enough time to ascertain what might even be "fair."

A general principle of insurance law is that once a claim has been paid, it is complete and settled and litigation is no longer a possibility. This measure creates uncertainty for insurance companies which could result in the potential for increased costs to the

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Gary M. Slovin
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policyholder. It would also create uncertainty for policyholders by increasing the potential for third party claims.

Furthermore, the language in the bill creates a new subjective standard of "fairness" as a measure for payments to be made. This is problematic because the bill also proposes to specifically establish a first party bad faith claim against the insurer. This would create a new class of lawsuits for policyholders who feel that their payments are not "fair."

For these reasons, we respectfully request the bill be deferred. Thank you very much for the opportunity to testify.

SENATE COMMITTEE
ON
COMMERCE AND CONSUMER PROTECTION

February 5, 2014

Senate Bill 2245 Relating to Insurance

Chair Baker and members of the Senate Committee on Commerce and Consumer Protection, I am Rick Tsujimura, representing State Farm Mutual Automobile Insurance Company (State Farm).

State Farm opposes Senate Bill 2245 Relating to Insurance. This legislation is unnecessary. Current law already adequately prescribes deadlines for responding to claims, and these standards are subject to regulatory oversight.

The Unfair Practices Act, 431:13-103(11) provides explicit requirements; subparagraphs (B) (15 days to respond to a communication), (F) (30 days to offer payment when liability is affirmed and the claim amount is determined), and (G) (duty to provide an explanation on unresolved claims within 30 days of date reported).

The proposed legislation introduces ambiguities where there is already clarity in the law and practice. Specifically, it is unclear what constitutes a demand, when it can be made, and by whom. With injury claims, an insured could make a demand long before it is clear what the injuries are. Even with property damage claims, a demand could be presented before anyone has had an opportunity to do an adequate investigation concerning liability. The current statute directly addresses these issues.

For the reasons outlined above we respectfully request the committee hold this measure. Thank you for the opportunity to present this testimony.

GEICO
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- Government Employees Insurance Company
- GEICO General Insurance Company
- GEICO Indemnity Company
- GEICO Casualty Company

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Senate Committee on Commerce and Consumer Protection
Conference Room 229 State Capitol
Wednesday, February 5, 2014, 9:00 a.m.
SB 2245 – Relating to Insurance

Chair Baker, Vice-Chair Taniguchi and Members of the Senate Committee on Commerce and Consumer Protection:

My name is Tim Dayton and I am General Manager for GEICO, Hawaii's largest insurer of motor vehicles. **GEICO opposes SB 2245 as it does not contain safeguards to confirm coverage, is vague, will limit the insurer's ability to fully investigate claims, will foster fraudulent claims and unnecessarily expose insurers to increased claims of bad faith.**

Under the current system, an insurer is required to determine coverage, liability, and damages. In the vast majority of cases, coverage is easily determined and quite clear. However, in some cases, it is not as clear and a coverage investigation is warranted; the investigation of both coverage and fraud can take more than 30 days. In such a case, the insurer would be in violation of the statute for not paying within 30 days, when it is still rightfully conducting a coverage

investigation. Further, this bill would provide an incentive for a plaintiff and counsel to withhold information and documentation to properly determine coverage. The process proposed in this bill would also increase insurer exposure to claims of bad faith and unfair dealing, without any protections of requiring that the insurer receive all relevant documentation and information with which to investigate coverage, determine liability, and evaluate the claim.

Further, the bill is vague. As written, it would require an insurer to pay what is "fair," a subjective standard. Requiring a carrier to advance settlement money early in the life of the claim may result in an inaccurate claim evaluation, particularly where information is later received that would demonstrate the value of the claim to be lower than initially thought, or the arbitration award is lower than the money advanced. The proposed bill provides no avenue for recovery in such cases.

The biggest potential impact would seem to be for Uninsured and Underinsured Motorists coverage (UM and UIM, respectively) the bill provides incentives for an insured's attorney to send incomplete medical information and documentation, with a request for payment within 30 days. This would result in claims being open longer, and would ultimately result in the insured being unable to obtain a final settlement and release. The compensation value of major injuries due a tort recovery is subjective and changes with discovery of facts including

prior history, an independent medical examination and verification of claimed injuries and disability.

With regard to Personal Injury Protection (PIP) coverage, current law states that "Payment of PIP benefits shall be made within 30 days after the insurer has received reasonable proof of facts...." An unscrupulous attorney could, under this proposal, make an argument that an insurer would be required to pay based on a received billing- or even simple treatment codes- but without the actual correlating proof of treatment notes, medical records, or narrative reports. This removes the insurer's ability to prevent fraudulent claims behavior, and removes the ability to investigate medical necessity, and reasonableness and appropriateness of treatment.

The bill as drafted would also remove a carrier's ability to send an itemized list of documents required for evaluation, in the name of preventing what claimants or plaintiffs would characterize as unwarranted delay, but which insurers would characterize as evidence necessary to properly evaluate a claim.

The bill is an attempt to "speed up" the first party claims settlement process. However, failure to keep adequate safeguards around the process to make sure that those steps are completed accurately would ultimately result in necessity to pay claims before coverage is determined, determination of liability, and over-payment of damages owed. This will raise the cost of motor vehicle insurance for Hawaii

insurance consumers. Additionally, the process described in this bill would increase motivation for plaintiffs to submit incomplete documentation for settlement, and provide an incentive for claimants to engage in fraudulent behavior and keep claims open longer, without the necessity of reaching a final settlement and release of claims. Finally, the process proposed by this bill would unnecessarily expose insurers to increased claims of bad faith. GEICO is unaware of any other state with this type of requirement and it has the potential to significantly increase the cost of motor vehicle insurance. Hawaii has followed the same approach common to most jurisdictions in the Unfair Claims Practices and I have attached an abbreviated version of this portion of the HRS. Specifically GEICO opposes this bill, and urges the members of this committee to **vote no on SB 2245.**

Thank you for the opportunity to submit this testimony.

Timothy M. Dayton, CPCU

Abbreviated version of the HRS

§431:13-103 Unfair methods of competition and unfair or deceptive acts or practices defined.

(a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured's beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Testimony of Woody Soldner in Support of S.B. 2245

Wednesday, February 5, 2014

9:00 am

To: Chairperson Rosalyn Baker and Members of the Senate Committee on Commerce and Consumer Protection:

My name is Woody Soldner and I am attorney who often assists consumers in making insurance claims for benefits following automobile crashes.

S.B. 2245 is needed to protect consumers and prevent insurance companies from using financial leverage to force consumers to accept an insurance company's position.

Consumers who have the foresight to financially protect themselves by purchasing uninsured and underinsured motorist coverage have a right, under certain circumstances, to make a claim for these benefits after being injured in a motor vehicle accident. When purchasing these benefits the consumer must pay the insurance company the insurance company's designated premium within 30 days or less.

By definition, consumers make claims for these insurance benefits when they have been injured in an accident involving an uninsured driver or an underinsured driver. The financially reality of life in Hawaii is that many of us are living paycheck to paycheck and being injured in an automobile crash can quickly result in inability to pay rent or a mortgage and even buy food for the family. All too often, I see families that fall apart after one of the breadwinners gets injured through no fault of their own. Thus, uninsured and underinsured motorist claims are frequently made when people are most vulnerable.

Insurance companies are well aware of the financial strain that is often brought about by being injured in a car crash. Unfortunately, some insurance companies exploit these consumers by refusing to timely pay benefits that the insurance company admittedly owes to the consumer.

This is done with the obvious effect of forcing the consumer to take the insurance company's valuation - - even though that valuation is grossly unfair - - just so these consumers can keep their home or put food on the table for their family.

S.B. 2245 would help to level the playing field by making it clear that insurance companies must pay, within 30 days, benefits that the insurance company admits are owed to the consumer. Any disputed amounts can then be resolved pursuant to the terms of the insurance policy and Hawaii law. This will allow the consumer to keep his or her head above water while seeking the fair value of their claim.

This bill is very important for the protection of consumers.

Thank you for the opportunity to present this testimony.

SB2245
Submitted on: 1/31/2014
Testimony for CPN on Feb 5, 2014 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
chris johnson	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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