SB765

Measure Title:	RELATING TO INSURANCE.
Report Title:	Uninsured Motorist; Underinsured Motorist; Prompt Claims Payment
Description:	Requires an insurer in a claim under uninsured or underinsured motorist coverage to pay to the claimant an amount the insurer deems reasonable within thirty days of a demand for payment of the claim. Requires any undisputed amount paid to a claimant to be disclosed to the arbitrator or judge and deducted from the amount of any judgment or award.
Companion:	
Package:	None
Current Referral:	CPN, JDL
Introducer(s):	SHIMABUKURO, Baker, Galuteria, Keith-Agaran, Ruderman

Sort by Date		Status Text
1/23/2015	S	Introduced.
1/26/2015	S	Passed First Reading.
1/28/2015	S	Referred to TRA/CPN, JDL.
1/29/2015	S	Re-Referred to CPN, JDL.
1/30/2015	S	The committee(s) on CPN has scheduled a public hearing on 02-03-15 9:00AM in conference room 229.

DAVID Y. IGE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

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TO THE SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

TWENTY-EIGHTH LEGISLATURE
Regular Session of 2015

Tuesday, February 3, 2015
9:00 a.m.

TESTIMONY ON SENATE BILL NO. 765 – RELATING TO INSURANCE.

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

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no postion on the bill, and submits the following comments:

This bill requires an insurer to pay a claimant, within 30 days of receipt of a demand for coverage under an uninsured motorist ("UM") or underinsured ("UIM") motor vehicle policy, the reasonable value of the claim. Resolution of a contested amount would be governed by the policy language. If litigation ensues, the amount paid would be disclosed to an arbitrator or judge.

We recommend that the term "insured" replace "claimant," and that mediators should join the list of interested parties who should be told the amount paid.

It should be noted that there are existing provisions in the Insurance Code, notably Article 13, that sets procedures and deadlines that they must follow in settling such claims.

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

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

Pauahi Tower, Suite 2010
1003 Bishop Street
Honolulu, Hawaii 96813
Telephone (808) 525-5877

Alison H. Ueoka
Executive Director

TESTIMONY OF MICHAEL TANOUE

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

Tuesday, February 3, 2015
9:00 a.m.

SB 765

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 thirty-six percent of all property and casualty insurance premiums in the state.

The Hawaii Insurers Council **opposes** SB 765.

SB 765 would require an automobile insurer to pay to a claimant in an uninsured motorist (UM) or underinsured motorist (UIM) claim an amount the insurer deems "reasonable," if any, within 30 days of a demand for payment. The Bill also provides that if the claim amount is still in dispute after payment, the dispute may be submitted for resolution to an arbitrator or judge, as set forth in the relevant policy. The undisputed amount already paid must then be disclosed to the arbitrator or judge at the commencement of the proceeding, and the undisputed amount previously paid is then deducted from the award. Finally, the Bill states that it shall not affect any recourse the claimant has against the insurer.

The Hawaii Insurers Council opposes this bill for several reasons.

First, a thirty-day deadline imposes unrealistic and unreasonable requirements on insurers. In most UM and UIM claims, the insurer does not receive sufficient information about liability disputes, 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.

Second, the word "reasonable" and the mandate to pay a "reasonable" amount in the Bill are either extraneous or too simplistic. On the one hand, if a "reasonable" 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 "reasonable" 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 "reasonable" amount ignores the difficult and time-consuming tasks required of insurers when they evaluate UM and UIM claims.

Third, disclosing to the arbitrator or judge the previous payment of the undisputed amount prejudices the insurer because that amount will serve as the "floor" on any award, thereby unfairly prejudicing the process. In claim evaluations, an amount deemed "reasonable" by a UM or UIM insurer could take into account several factors,

such as litigation costs, which are not directly related to an objective evaluation of the claim value. Therefore, a "reasonable" amount from the insurer's standpoint could be higher than an actual award, unless, as the Bill unfairly dictates, the amount of that settlement must be disclosed to the judge or arbitrator. Under this Bill, UM and UIM awards would be artificially inflated by this disclosure requirement.

Finally, the mere statement that the Bill "shall not affect any recourse the claimant may have against the insurer" is a thinly veiled and unnecessary threat against insurers that, again, could have the undesirable effect of spiking awards higher than an objectively "reasonable" value. Honest disagreements about "reasonable" values, especially at a very early stage of the claim process, should not be punished by threats of "recourse."

Based on the foregoing, the Hawaii Insurers Counsel opposes SB 765 and requests that it be held. Thank you for the opportunity to testify.

Property Casualty Insurers
Association of America
Advocacy. Leadership. Results.

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

From: Mark Sektnan, Vice President
Property Casualty Insurers Association of America

Re: **SB 765 – Relating to Insurance**
PCI Position: Oppose

Date: Tuesday, February 3, 2015
9:00 a.m., Room 229

Aloha Chair Baker and Members of the Committee:

The Property Casualty Insurers Association of America (PCI) **opposes SB 765** which would require payment within thirty days for uninsured motorist and under insured motorist 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. This bill would make it an unfair claims practice not to pay any "undisputed" amount within 30 days of "demand", it does not specify who can make such a demand. These claims could come from the claimant, a body shop, medical clinic or a contractor as well as an attorney. This bill seems to be overly broad and could be used by providers to leverage insurers in to paying non meritorious claims.

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 requirement 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.

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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 2, 2015

Filed via electronic testimony submission system

RE: SB 765, Insurance; Motor Vehicle Insurance; UM/UIM; Prompt Payment - NAMIC's Written Testimony for Committee Hearing

Dear Senator Baker, Chair; Senator 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 3, 2015, 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.

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 765:

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 UM/UIM 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 765 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 765 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 765 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 is involved in an accident by a vehicle that either flees the scene or the at-fault driver provides false or fraudulent insurance information about having coverage when the driver is actually uninsured, the UM insurer may not have all the key information (important information outside of the control of the insurer) to determine if there is a UM claim. Additionally, in UIM claims, the insurer has to wait for the policyholder to submit a claim and work out a settlement with the underinsured at-fault driver and his insurer before the UIM insurer can reasonably start to figure out UIM damages. The proposed legislation doesn't take these types 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 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 765 misplaces legal emphasis upon speed as opposed to accuracy in the claims settlement process.

3) SB 765 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 765 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 765 that states, "this section shall not affect any recourse the first party claimant may have against the insurer." NAMIC is concerned that SB 765 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 765 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 arguably 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.

In closing, NAMIC respectfully requests that the Senate Committee on Commerce and Consumer Protection "**VOTE NO**" on SB 765, 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.

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.

Respectfully,

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

SENATE COMMITTEE
ON
COMMERCE AND CONSUMER PROTECTION

February 3, 2015

Senate Bill 765 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 765 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), particularly 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), (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.

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

DATE: February 2, 2015

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

RE: **S.B. 765 – Relating to Insurance**
Hearing Date: Tuesday, February 3, 2015 at 9:00 a.m.
Conference Room: 229

Dear Chair Baker and Members of the Committee:

We submit this testimony in **opposition** to S.B. 765 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 this bill because it requires an insurer in a first party insurance claim to pay the claimant a 'reasonable' 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 an offer of payment within 30 days if a claim is determined and not in dispute. Proponents claim that insurers are fabricating disputes to avoid paying what is undisputed, but, other than unverified anecdotal accounts from plaintiff attorneys, there is no evidence to indicate that insurers are acting unfairly. Oftentimes, in complicated situations like multi-vehicle accidents or accidents where severe injuries limit the parties' availability, 30 days is not nearly enough time to ascertain what might be "reasonable." This works for simple cases but certainly not for complex ones. In such complex matters, the insurer usually does not even have control over the parties that have the information needed to determine what the facts are and what is reasonable. Expecting such matters to

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be fully analyzed within 30 days is itself not reasonable. Whether it is the intention or not, the result of the proposed legislation would be to set up significant potential for bad faith claims against insurers.

For these reasons, we respectfully request the bill be deferred.

Thank you very much for the opportunity to testify.

SB765
Submitted on: 1/31/2015
Testimony for CPN on Feb 3, 2015 09:00AM in Conference Room 229

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

Comments: Thank you for this bill Senator Maile! Am very familiar with the pain and anxiety that comes when an accident victim who was not responsible for an accident that ruined her car and body tries to get reimbursement to help deal with immediate needs.. I had to wait 9 months for USAA insurance to admit their client, a doctor and lt coronel in the military sped thru a red light and almost killed me and destroyed my car and bones. It then took another 10 months for them to even send me money for my car which was demolished. They were insulting and rude. and mean. I hope this is just the beginning of change to help those harmed.. in no fault insurance.. it's everyone's fault when victims are ignored and those responsible are protected by their insurance companies..

SB765
Submitted on: 2/1/2015
Testimony for CPN on Feb 3, 2015 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Nancy Jones	Hydroponics Alternatives LLC	Comments Only	No

Comments: We submit this testimony supporting SB 765 to compel insurers in a claim under uninsured or underinsured motorist coverage to pay claimants an amount the insurer deems reasonable within thirty days of a demand for payment of the claim. SB 765 would also require any undisputed amount paid to a claimant to be disclosed to the arbitrator or judge and deducted from the amount of any judgment or award. For this reason, we respectfully urge you to support SB765 and pass it out of your committee. Thank you for this opportunity to present comments supporting this measure.