

AB 459 (Continued)

This bill (pages 4 and 5) would add to the list of unfair methods of competition and unfair and deceptive acts and practices 13 specified unfair claims settlement practices.

The Department of Insurance advises that, as the bill serves primarily to make more specific the prohibitions against unfair practices already implied in the law, no increased state cost is anticipated under the measure.

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# ENROLLED BILL REPORT

AGENCY Agriculture and Services	BILL NUMBER AB 459
DEPARTMENT, BOARD OR COMMISSION Department of Consumer Affairs	AUTHOR Pierson, et al

**SUBJECT:**

Adds 13 "unfair claims settlement practices" to Insurance Code for violation of which the Insurance Commissioner may take specified actions to restrain continuation of practice.

**HISTORY, SPONSORSHIP AND RELATED LEGISLATION:**

This bill is sponsored by the author and supported by the Department of Insurance and Department of Consumer Affairs. The bill passed the Senate on the Consent File and there are no bills which are related.

**ANALYSIS:**

**A. Specific Findings**

This bill is designed to make the law more specific in some areas which have been ambiguous by enumerating a list of specific activities which may be considered unfair claims settlement practices. The Department of Insurance is in support of the measure and believes that the practical effect may be substantial. That department feels that their powers will remain largely the same as they are at present, although, the language of the law will not have to be interpreted so broadly as is now the case. They also believe that the language of this bill will enable them to get involved in some third party disputes which they do not become involved in at present. The effect of this bill on the consumer will depend largely on how the Department of Insurance uses it in practice. It may make the Department of Insurance more aggressive in dealing with insurance businesses if the ambiguity which now exists has made the department somewhat timid in exercising its powers. This bill should allow the department to become more effective in its consumer protection activities.

**B. Fiscal Analysis**

No mandatory fiscal impact. However, additional funds for implementation may be sought at some point.

This department maintained an approved support position.

**RECOMMENDATION:**

Sign.

PE-3

DEPARTMENT DIRECTOR J. K. ...	DATE 8/9/72	AGENCY SECRETARY [Signature]	DATE AUG 8 1972
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# Memorandum

To : Mr. Leo M. Hirsch

Date: March 23, 1972

From : Department of Insurance - F. Joseph O'Regan  
1407 Market St., San Francisco 94103

Subject : Assembly Bill 459

*National Association  
of Insurance Commissioners*

This bill is based upon NAIC recommended amendments to the NAIC Model Unfair Trade Practices Act. ~~NAIC adopted the amendments in December 1971. As a result, the Unfair Trade Practices provisions of the Insurance Code appear in Sections 790 to 790.09 and those sections are not subject to the monetary penalties provided under Section 704.7, during the 1971 session.~~ This proposal needs amendments to clarify whether some of the subdivisions apply to an insured of the insurer or to third party claimants or to both. If made a part of Article 6.5 of Chapter 1 of Part 2 of the Insurance Code (Sections 790 to 790.09), and clarified, ~~by the amendments,~~ the Insurance Department would support enactment of this proposal.

*File*

*Substantial*

*F. Joseph O'Regan*  
F. JOSEPH O'REGAN

FJO:jy

cc: Commissioner Barger  
Mr. L. C. Baker, Jr.

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# BILL ANALYSIS

# BUSINESS AND TRANSPORTATION AGENCY

DEPARTMENT Department of Insurance	AUTHOR Pierson and others	BILL NUMBER AB 459
SPONSORED BY Assemblyman Pierson	RELATED BILLS	DATE LAST AMENDED Original

**BILL SUMMARY**

The bill lists various practices as "unfair claims settlement practices"; requires insurers to keep a record of complaints and provides for penalties for failure to do so.

**ANALYSIS**

This bill is based upon National Association of Insurance Commissioners recommended amendments to the National Association of Insurance Commissioners Model Unfair Trade Practices Act. The Unfair Trade Practices provisions of the Insurance Code appear in Sections 790 to 790.09 and those sections are not subject to the monetary penalties provided under Section 704.7.

This proposal needs substantial amendments to clarify whether some of the subdivisions apply to an insured of the insurer or to third claimants or to both. If made a part of Article 6.5 of Chapter 1 of Part 2 of the Insurance Code (Sections 790 to 790.09), and clarified, the Insurance Department would support enactment of this proposal.

RECEIVED  
 1972 APR 11 PM 1:10  
 DEPARTMENT OF INSURANCE  
 SAN FRANCISCO

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**FISCAL IMPACT**

None

**POSITION** Neutral

Governor's office use

Position noted	<input type="checkbox"/>
Position approved	<input checked="" type="checkbox"/>
Position disapproved	<input type="checkbox"/>

DEPARTMENT DIRECTOR <i>[Signature]</i>	DATE 4/6/72	AGENCY ADMINISTRATOR Original Signed by Larry Tilton	DATE APR 5 1972
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EMH

# BILL ANALYSIS

BUSINESS AND TRANSPORTATION AGENCY

DEPARTMENT Department of Insurance	AUTHOR PIERSON, et al	BILL NUMBER AB 459
SPONSORED BY ASSEMBLYMAN PIERSON	RELATED BILLS	DATE LAST AMENDED 4/17/72

**BILL SUMMARY**

The bill lists various practices as "unfair claims settlement practices"; requires insurers to keep a record of complaints and provides for penalties for failure to do so.

**ANALYSIS**

This bill is based upon National Association of Insurance Commissioners recommended amendments to the National Association of Insurance Commissioners Model Unfair Trade Practices Act. The Unfair Trade Practices provisions of the Insurance Code appear in Sections 790 to 790.09 and those sections are not subject to the monetary penalties provided under Section 704.7.

This proposal was amended in accordance with our comments made in the analysis of the original bill. Accordingly, it is now good legislation.

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**FISCAL IMPACT**

N O N E

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<b>POSITION</b>		S U P P O R T		Governor's office use	
				Position noted	<input type="checkbox"/>
				Position approved	<input checked="" type="checkbox"/>
				Position disapproved	<input type="checkbox"/>
DEPARTMENT Leo M. Hirsch, Counsel	DATE 4-21-72	AGENCY ADMINISTRATOR Leo M. Hirsch	DATE APR 27 1972	RU 4/5	

# news release

RICHARDS D. BARGER  
INSURANCE COMMISSIONER

CALIFORNIA DEPARTMENT OF INSURANCE

1407 Market Street  
San Francisco, California 94103

August 16, 1972

## PRESS RELEASE

### FOR IMMEDIATE RELEASE

### GOVERNOR REAGAN OF CALIFORNIA SIGNS MAJOR INSURANCE CONSUMER BILL OF THIS SESSION

Governor Reagan has signed Assembly Bill 459, authored by Assemblyman David Pierson of Inglewood, Chairman of Assembly Finance and Insurance Committee, and co-authored by Senator Carrell in the Senate, which is a major and comprehensive revision of the Model Unfair Practices Insurance Act. The bill is the major piece of consumer insurance legislation in this session of the California Legislature. The law is patterned upon a Model Bill developed by the National Association of Insurance Commissioners while California Insurance Commissioner Richards D. Barger was President of the NAIC, and specifies 13 unfair claims settlement practices which, if engaged in as a general business practice by an insurer, authorizes the Insurance Commissioner to issue Orders against the insurance company.

Included in the list of specified unfair claims settlement practices are: misrepresentation to claimants as to the types and amounts of coverage; failure of the insurer to make a prompt investigation of a claim; failure of an insurer to promptly communicate with its insureds in response to questions from insureds; failure of an insurer to make a prompt, fair, and equitable settlement when the liability of the insurer has become reasonably clear; an insurer forcing insureds to institute court action because the insurer offers unfair claims settlement amounts; an insurer requiring claimants to file unnecessary statements by physicians when any such subsequent statements would contain substantially the same information as the information furnished in the first statement by the physician; failure of an insurer to provide a prompt explanation to the insured of the reasons for denying a claim or refusing to accept a compromise settlement offered by the insured.

-More-

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Mr. F. Joseph O'Regan  
Chief Assistant Insurance Commissioner

September 19, 1973

- Leo M. Hirsch

Assembly Bill 459 (1972)  
Unfair Claims Settlement Practices

Mrs. Yee advised me that you requested a memorandum from me, explaining why the provisions of the subject bill were removed from Section 704 and inserted as part of Section 790.03. I have no independent knowledge of why this was done. I did not discuss the subject bill with members of the industry nor did I participate in any discussions which you or the Commissioner may have had with industry concerning the bill.

You advised me by memorandum dated March 23, 1972, that the bill was based upon NAIC recommended amendments to the NAIC Model Unfair Trade Practices Act. You pointed out that the Unfair Trade Practices provisions of the Insurance Code appeared in Sections 790 to 790.09 and that "those sections are not subject to the monetary penalties provided under Section 704.7." I have enclosed a copy of that memorandum. The mark-up of the memorandum was done for the purpose of incorporating it in our analysis which was sent to the Business and Transportation Agency with a recommended "Neutral" position. I have also attached a copy of our Bill Analysis of the original bill.

I have also attached a copy of our Bill Analysis of the bill as amended on April 17, 1972, after the provisions were added as subdivision (h) of Section 790.03 and no longer "subject to the monetary penalties". We then recommended a "Support" position.

I have no other information concerning the change.

(1) I believe you would like +  
(2) monetary

LEO M. HIRSCH

LHJ:kd

Attachments

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LAW OFFICES

*Gerald S. Shacter*

9465 WILSHIRE BOULEVARD, SUITE 518 • BEVERLY HILLS, CALIFORNIA 90212 • 213/274-9834

March 12, 1974

E. G. Dunn, Insurance Officer  
DEPARTMENT OF INSURANCE  
State of California  
600 South Commonwealth Avenue  
14th Floor  
Los Angeles, California 90005

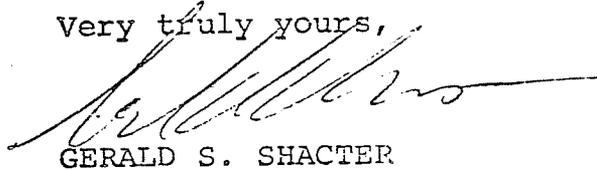
Re: Edith Bailey and Southwest Solvents

Dear Mr. Dunn:

Per our conversation this morning, I am sending you a copy of Mr. Wasserman's article which appeared in the Beverly Hills Bar Journal issue of November-December, 1973. I would direct your attention, particularly, to the last paragraph of Page 20, continuing on Page 21.

Please let me know as soon as you have had an opinion as to the applicability of this section to complaints by third party claimants.

Very truly yours,



GERALD S. SHACTER

GSS:deb  
Enclosure

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State of California

# Memorandum

To : A. R. Garza

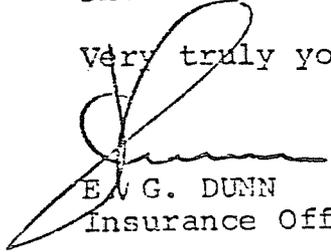
Date: April 2, 1974

From : E. G. Dunn  
Department of Insurance  
690 South Commonwealth Avenue, Los Angeles 90005

Subject: Attached Three Special G. C. Files

Whereas we have written to attorneys stating that Section 790.03 of the California Insurance Code does not apply to third party claims. One of the attorneys, Gerald S. Shacter, has replied with the attached excerpt which appeared in the Beverly Hills Bar Journal which seems to indicate that this particular section does apply to third party complainants. Possibly this is something for which a ruling should be issued.

Very truly yours,

  
E. G. DUNN  
Insurance Officer

EGD/nk

T/11



# Memorandum

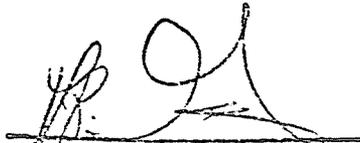
To : Ms. Angele Khachadour, Chief  
Legal Division, San Francisco

Date: April 5, 1974

From : Department of Insurance - A. R. Garza  
600 South Commonwealth Avenue, Los Angeles 90005

Subject: Unfair Claims Practices Act - Gerald S. Shacter,  
Richard C. Dunsay and Victor Dirnfield

Attached is a memo to me from Insurance Officer, E. G. Dunn, copy of a letter from Legal Counsel, Gerald S. Shacter and a copy of an article appearing in the Beverly Hills Bar Journal which informs the readers that third party claim matters are covered under Section 790.03. The policy of the Policy Services Bureau in Los Angeles is to not entertain third party complaints as a matter of practice and we do not consider third party claims to be included under the Unfair Claims Practices Act. We could be wrong, however, before we change our procedures, it would be appreciated if you or one of your lawyers can advise us of the department's position from a legal standpoint so that we may be guided by it.

  
A. R. GARZA

ARG:bb

cc - Barry Bertram  
Attachments



Memorandum

*1/10/1974* *ent*

To : Mr. Barry Bertram  
Los Angeles Office

Date:

RECEIVED  
1974 MAY -7 PM 1:44  
APRIL 26, 1974  
RECEIVED BRANCH  
SAN FRANCISCO

1974 APR 29 AM 9 13

From : Department of Insurance  
1407 Market St., San Francisco 94103

- Angele Khachadour

Subject: Unfair Claims Practices Act

DEPARTMENT OF INSURANCE  
LOS ANGELES

By memorandum dated April 5, 1974, Mr. A. R. Garza requested advice as to whether the 1972 enactment of the Unfair Claims Settlement Standards now requires that this Department entertain third party complaints.

Attached is a memorandum from Leo Hirsch in which he concludes that with the exception of subparagraphs (6), (7), (8) and (9), these claims standards appear to have been knowingly designed to cover third party claims. I fully concur with his conclusions.

It is my recommendation that our position vis a vis third party claims be reconsidered and appropriate procedures and guidelines be developed for the PSB Staff since we could subject ourselves to criticism for our failure to enforce those provisions of Insurance Code Section 790.03(h) applicable to such claims.

ANGELE KHACHADOUR

AK:lm  
Att.

cc: Commissioner Payne  
Mr. Baker  
Mr. Garza

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DI-B

Ms. Angele Khachadour

April 24, 1974

- Leo M. Hirsch

Unfair Claims Settlement Practices  
Assembly Bill 459, Chapter 725 (1972)

This is in response to your request for my views on the material furnished to you by Mr. Garza concerning the subject.

When AB 459 was being considered in 1972, I raised the question about whether any of the 13 items appearing under Subdivision (h) were intended to affect third party claims. The language did not make that clear. Subdivisions (2) and (3) referring to "claims arising under insurance policies" were, at best, ambiguous. Items (4) and (13) contained language which can be equally applied to third party or first party contracts. The word "liability" appeared in Subdivisions (5) and (12). That word can be better applied to third party matters than to first party claims. Subdivisions (1), (10) and (11) used the word "claimant" or "claimants", which are only used in third party matters. This leaves Subdivisions (6), (7), (8) and (9) as the only items which can be reasonably construed to be applicable only to first party claims.

When the bill was being considered, I testified before legislative committees and talked to the staff of the legislative committees, stating that the bill could be construed to affect third party matters. Nobody argued against that position.



*Leo Hirsch*  
*S. F.*

C. R. Scott  
A. R. Garza  
J. Petkovich  
Leo Hirsch

May 31, 1974

- Barry Bertram

Handling Complaints in connection with Third Party Claims  
as they apply to the Unfair Trade Practices Act

As a result of our discussions on May 30, 1974, we concluded that any complaints of third parties that included any of the following elements, a file would be opened and the matter would be investigated:

- 1) The company assumed liability but had not paid the claim;
- 2) There was obvious liability but no settlement had been offered or negotiated;
- 3) The insurer had not sent any letter to the third party acknowledging receipt of the claim;
- 4) There was obvious liability but the insurer was making continuing and repeated demands for the same or additional information to a point of harassment;
- 5) The insurer was following the practice of offering less than the value under property damage claims, such as in total losses of an automobile.

We also concluded that it was permissible to send a copy of the letter of complaint to the insurer. In addition, a form letter will be drafted and sent at a later date for your review to be sent to the insurer as a first letter in connection with the investigation of the complaint. We will also prepare a form letter to be uniformly used in our three offices with respect to acknowledging the receipt of the complaint and advising the complainant to be certain that he protects his rights under any statute of limitations. Please let me know if you have any suggested changes in this memo.

BARRY BERTRAM

BB:cr

C  
O  
P  
Y

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Richard Barnes, Colorado; Hon. Johnnie L. Caldwell, Georgia; Hon. James Baylor, Chicago; Hon. Russell E. Van Hooser, Michigan; Hon. Robert L. Clifford, New Jersey; Hon. Benjamin R. Schenck, New York; Hon. Herbert S. Denenberg, Pennsylvania; Hon. Clay Cotton, Texas.

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FIRST REPORT OF THE  
INDUSTRY ADVISORY COMMITTEE  
TO THE NAIC B-5 SUBCOMMITTEE TO REVIEW  
THE MODEL UNFAIR TRADE PRACTICES ACT  
JUNE 16, 1971

I. The Industry Advisory Committee's Assignment.

The Industry Advisory Committee held its initial meeting, at the request of the NAIC, at the Zone V meeting in Santa Fe, New Mexico on April 26. Immediately following that meeting we met with the B-5 Subcommittee for the purpose of reviewing the subject generally and for a discussion of the scope and direction of the Industry Advisory Committee's activities. As a result of that meeting Commissioner Durkin, as co-chairman of the Subcommittee, on May 14th distributed a letter setting forth various items which the Industry Advisory Committee was to consider. Those items fall into the following categories:

A. Addition of "Defined" Unfair Trade Practices. There was considerable interest among the Subcommittee members as to the possibility of adding additional specific examples of unfair trade practices to Section 4 of the Model Act. Section 4 now covers misrepresentations and false advertising of policy contracts; false information and advertising generally; defamation; boycott, coercion and intimidation; false financial statements; stock operations and advisory board contracts; unfair discrimination in life insurance, annuities and health insurance; and rebates. A number of specific suggestions were given to the Advisory Committee for its consideration.

B. Streamlining Administrative Procedures. Some question was raised as to whether the Model Act had enough "teeth" in it. As currently drafted, (Section 5 to 8 and 11 the Act relies chiefly upon a cease and desist order, following a hearing, as the means of remedying a "defined" unfair trade practice. It is only after a cease and desist order has been violated that the Commissioner may impose a monetary penalty upon a licensee. In addition, there was sentiment among the Commissioners to the effect that the method of determining the controlling non-defined unfair trade practices was too cumbersome. Under Section 9 of the Model Act, a Commissioner has the authority to review specific trade practices used by a licensee to determine if such practices are unfair. This requires a notice and hearing involving the specific licensee. The Commissioner makes his determination but has no power to order the licensee to desist from such practices. He is required (under Section 10) to resort to the courts for the issuance of an injunction in order to enforce his findings.

C. Power to Issue Regulations. The Model Act does not confer any authority upon the Commissioner to promulgate regulations. Some commissioners thought the Act could be made more effective if some authority was added in this area. One suggestion for consideration was to give the Commissioner the power by regulation to add new specific acts to the unfair trade practices

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enumerated in Section 4.

D. Consumer Class Actions. As a result of the various federal proposals to create consumer class actions for damages produced by the commission of unfair trade practices, some of which proposals would include insurance services, the Advisory Committee was asked to be ready to discuss this subject. The proposals in this area include: 1) unlimited class action rights; 2) a right to a class action triggered only by a finding by the Commissioner that an unfair trade practice has been committed; and 3) empower the Commissioner to sue on behalf of injured members of a class for damages sustained.

E. "Group Insurance" and "Credit Insurance". The Subcommittee also requested that we be prepared to discuss the subject of "group insurance". Presumably, "group" auto and property insurance, and "credit insurance". A number of state laws now prohibit, as an unfair trade practice, the fictitious grouping of property, casualty or surety risks for rating purposes. No specific items were directed to us for consideration in this area.

F. New Hampshire Bill Revising Unfair Trade Practices Act. Commissioner Durkin distributed, for discussion purposes and not as a committee draft, a proposed revision of the New Hampshire Unfair Trade Practices Act, which incorporates, in substance, most of the revisions to the Model Act which were suggested by the various members of the Subcommittee. This proposal has since been introduced in the New Hampshire legislature.

The Industry Advisory Committee met on June 3rd in Chicago to consider these items, and others, and as a result of that meeting is prepared to offer a number of recommendations for revision of the present Model Act. However, we are not prepared at this time to present specific language to incorporate such recommendations into the Model Act.

In the performance of its assignment the Industry Advisory Committee reviewed the history of the NAIC Model Act, compared the Model Act to the Federal Trade Commission Act and also researched the laws of all 50 states to identify any substantive departures from the Model Act. It may be useful for the record to reflect the results of this research before getting to the specific comments and recommendations we wish to offer with respect to the Model Act.

## II. History and Purpose of NAIC Model Unfair Trade Practices Act.

In response to the enactment of the McCarran Act in 1945 the NAIC, assisted by an all-industry committee, developed a "Model Act relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance." The All-Industry Committee Draft of January 24, 1947 was approved as a Model Act by the NAIC at its Annual Meeting in June 1947.

The purpose of the Model Unfair Trade Practices Act, as stated therein, is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of all such practices which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

We direct your attention to pages 145 et seq. of the 1959 Proceedings of the NAIC, Vol. I, for a good discussion of the Model Act in the context of the McCarran Act. The Model Act is also treated in the following portions of the NAIC Proceedings:

1947 Proc. Pages 383-410  
1959 Proc. Vol I, Pages 145-147  
1960 Proc. Vol II, Pages 509-515  
1961 Proc. Vol I, Pages 309-316

### III. Comparison of Model Act with Federal Trade Commission Act.

The NAIC Model Act is patterned very closely after the Federal Trade Commission Act (15 U.S.C.A. Sec. 45) and much of the language was lifted bodily from the federal law. The Model Act, with its broad prohibition against unfair or deceptive acts or practices parallels the FTC Act, but unlike the federal law, it enumerates certain defined acts or practices peculiar to the business of insurance. Since any such enumeration could not cover every conceivable situation, the Model Act contains an omnibus provision (Section 9) virtually identical with a provision of the FTC Act.

In addition, both acts contain similar enforcement provisions. The persons charged with enforcement of the acts are given the authority to examine and investigate, conduct hearings, and issue cease and desist orders, which are subject to judicial review. Even the penalty provisions of the two acts are identical.

### IV. Enactment of the NAIC Model Act and Subsequent Expansion.

All fifty states have enacted unfair trade practice statutes, most of which contain provisions identical or substantially similar to the Model Act. The State of Oregon and the District of Columbia have not enacted the Model Act, however, the statutes which have been enacted in those two jurisdictions contain a series of provisions prohibiting all of the unfair methods of competition and deceptive acts included in the Model Act, and provide the Insurance Commissioner with the necessary powers of enforcement.

Although a number of states omitted Section 9, the omnibus provision, from the Model Act when originally enacted, the great majority of states now include in their statutes a similar provision which gives the Insurance Commissioner the authority to file charges against any insurer or any person when he has reason to believe that such insurer or person is engaging in an unfair practice which is not specifically defined in the statute. After holding a hearing and making appropriate findings, the Commissioner may request the attorney general of his state to bring an action to enjoin the continuation of such unfair act or practice or unfair method of competition.

A large number of states have broadened the coverage of the Model Act by specifically prohibiting other activities which are declared to be unfair trade practices; for example, interlocking directorates, dealing in premiums, fraudulent statements in applications, favored broker arrangements, offering insurance as to inducement to purchase commodities, and unreasonable delay or refusal to pay claims as a general business practice.

### V. Recommendation on Suggested Revision of the Model Act.

A. Addition of Defined Unfair Trade Practices. In considering what additional "defined" unfair

Halbert L. Carter, Jr., Tennessee; Hon. Clay Cotten, Texas; Hon. Stanley C. DuRose, Wisconsin.

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### UNFAIR TRADE PRACTICES (B6) SUBCOMMITTEE

Reference:

1971 Proc. Vol II p. 341

W. Fletcher Bell, Co-Chairman  
John A. Durkin, Co-Chairman

Kansas  
New Hampshire

#### AGENDA

1. Review of the June, September and November meetings of the (B6) Subcommittee.
2. Receive any presentations by the Industry Committee.
3. Open discussion of regulator's draft.
4. Executive Session.
5. Any other matters submitted for consideration.

A meeting of the Subcommittee was held in the East Ballroom of the Fontainebleau Hotel, Miami Beach, Florida on November 29, 1971. A quorum was present.

Co-Chairman Durkin briefly discussed the meetings of the Subcommittee which had been held in April, June, August (in Milwaukee), September (in Detroit) and November 2-3, 1971 in Chicago, Illinois.

The Milwaukee meeting resulted in the regulators first working draft of revisions to the NAIC Model Unfair Trade Practices Act. The Milwaukee draft was presented to the Industry Advisory Committee and reviewed in detail by the Subcommittee at the September meeting in Detroit. Changes in the Milwaukee draft, as a result of the Detroit meeting, were incorporated into what became known as the Detroit draft.

The Subcommittee met jointly with the Industry Advisory Committee in Chicago to discuss the revisions arising out of the Detroit draft. As a result of the Chicago meeting the bill was redrafted and distributed to members of the Subcommittee and the Industry Advisory Committee shortly before the Miami meeting.

At the Miami meeting, following remarks by Commissioner Durkin, Mr. Robert Seiler, as chairman, presented the report of the Industry Advisory Committee, a copy of which is attached to this report. In addition to Mr. Seiler, oral statements were made by William McCrae of the United States Automobile Association, Robert Gilmore of the American Insurance Association, Arthur Mertz of the National Association of Independent Insurers, Robert Demichelis representing the American Life Convention, Life Insurance Association of America, and the Health Insurance Association of America and John Hamilton of the American Mutual Insurance Alliance.

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The Subcommittee resolved itself into Executive Session to review the Chicago draft and consider suggestions offered by the Industry Advisory Committee. The attached copy of the bill as recommended by the Subcommittee resolves the questions set forth in the Advisory Committee recommendations.

The Subcommittee points out that several other areas were discussed but are not part of the recommended bill.

With respect to class action provisions, the final decision of the Subcommittee was that a provision relating to class actions was inappropriate at this time in view of the circumstances. Furthermore, the Subcommittee felt that the remedies in the model bill provide broad relief, thus affording the insurance consumer the complete protection of the Insurance Department, including Insurance Department complaint handling mechanisms, which has proved to be a most effective mode of redress. In addition, the Subcommittee felt that a provision with respect to class actions might restrict rather than expand the relief possible.

The Subcommittee reviewed several drafts of possible provisions concerning the underwriting practices of insurers. That is, we considered provisions which would have restricted the right of insurers to reject persons as risks solely because of race, color, creed, marital status, sex, national origin, residence, age, lawful occupation, failure to place collateral insurance, or previous refusal by another insurer. We decided not to incorporate such provisions because:

- (1) Some of these matters are presently covered in civil rights laws;
- (2) Some of these points are covered by special statutes relating to auto insurance; and
- (3) The broad philosophical implications would appear to make the treatment of this subject more appropriate in a separate bill. The Subcommittee does recommend, however, that the Automobile Insurance Problems Subcommittee appoint a task force to prepare model legislation.

The Subcommittee recommends the attached revised Model Unfair Trade Practices Act for adoption by the NAIC. This act is a strong, consumer-oriented measure which gives the Insurance Commissioner more power to deal with unfair and deceptive practices than is possessed by most other state regulatory officials. It should be hailed as another NAIC landmark.

Although complete comprehension of the effectiveness and potential of this act requires a careful reading, we have set forth briefly below the areas we hope to resolve:

- (1) It clarifies and expands the defined unfair trade practices and brings Blue Cross and Blue Shield under its terms. The new provisions include treatment of unfair claim settlement practices, failure to maintain complaint handling procedures, and misrepresentation in insurance applications.
- (2) Insurer claims practices are a continuing source of criticism and concern. In the



past it has been difficult for both regulators and insurers to solve these problems because there have been no ground rules. This new provision sets out the standards the Subcommittee thinks are desirable.

(3) Complaint handling procedures are of increasing interest to regulators. The efficiency with which complaints are handled is a test of the public confidence due the insurer. In addition, reporting of complaint handling data will reveal much about the effectiveness of the laws, regulations and other regulatory tools used by insurance departments.

(4) Misrepresentation in insurance applications was not clearly covered by the present law. For this reason we have made it clear that such actions are prohibited.

(5) It prohibits discrimination by creditors in favor of certain insurers or agents and it prohibits coercion of debtors with regard to insurance. This section expands the scope of the law, but since the abuses relate directly to insurance they fit the purpose of this law and are a proper concern.

(6) It greatly strengthens the enforcement procedures in the model bill. Every department contacted by this Subcommittee expressed dismay and discontent with the present enforcement powers. To accomplish the changes, the Subcommittee made clear

(a) That hearings may be held and penalties applied for violations of both defined and undefined unfair trade practices;

(b) That the optional penalties for violations of defined unfair trade practices include, in addition to cease and desist order, payment of monetary penalties, suspension and revocation of licenses, and other relief as is reasonable and appropriate,

(c) That the commissioner may promulgate rules and regulations further clarifying the defined unfair trade practices.

The Subcommittee would like to extend special thanks to the Industry Advisory Committee chaired by Robert Seiler for the intensive and excellent work they have done on this revision. It is our request that they remain in existence as an Industry Advisory Committee at least until the Denver NAIC meeting to report to us the positions taken on the model bill by the various organizations they represent.

Finally, the Subcommittee wishes to thank the Insurance Departments of Illinois and Colorado, who are not now on the Subcommittee, but who greatly assisted the work of the Subcommittee.

There being no further business, the Subcommittee adjourned.

Hon. W. Fletcher Bell, Co-Chairman, Kansas; Hon. John A. Durkin, Co-Chairman, New Hampshire; Hon. Johnnie L. Caldwell, Georgia; Hon. William H. Huff, III, Iowa; Hon.

Russell E. Van Hooser, Michigan; Hon. Samuel Van Pelt, Nebraska; Hon. Robert L. Clifford, New Jersey; Hon. Benjamin R. Schenck, New York; Hon. Kenneth E. DeShetler, Ohio; Hon. Herbert S. Denenberg, Pennsylvania; Hon. John W. Lindsay, South Carolina.

AN ACT  
RELATING TO UNFAIR METHODS OF COMPETITION AND  
UNFAIR AND DECEPTIVE ACTS AND PRACTICES IN THE  
BUSINESS OF INSURANCE\*

SECTION 1--DECLARATION OF PURPOSE.

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

SECTION 2--DEFINITIONS.

When used in this Act:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters. Person shall also mean medical service plans and hospital service plans as defined in Section . For purposes of this Act, medical and hospital service plans shall be deemed to be engaged in the business of insurance.

Drafting Note: This definition could also include dental, optometric, and other service plans. The enabling statutes of all service plans should also be amended to make them subject to this Act.

(b) ("Commissioner") shall mean the (Commissioner) of Insurance of this state.

(c) "Insurance policy" or "insurance contract" shall mean any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person.

Drafting Note. Each state may wish to consider the advisability of defining "insurance" for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient. "Service contract" is intended to cover the product issued by medical and hospital service plans and should be changed to conform to the laws of each state.

SECTION 3--UNFAIR METHODS OF COMPETITION OR AND UNFAIR AND OR DECEPTIVE ACTS OR PRACTICES PROHIBITED.

No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to Section 7 of this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

SECTION 4--UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED.

The following are hereby defined as unfair methods of competition and unfair ~~and~~ or deceptive acts or practices in the business of insurance:

(1) MISREPRESENTATIONS AND FALSE ADVERTISING OF POLICY CONTRACTS INSURANCE POLICIES. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or, statement, misrepresenting the terms of any policy issued or to be issued or the sales presentation, omission, or comparison which:

\*As adopted by the (B6) Subcommittee.

(a) misrepresents the benefits or advantages promised thereby, conditions, or terms of any insurance policy; or

(b) misrepresents the dividends or share of the surplus to be received thereon, on any insurance policy; or making

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, any insurance policy; or making any

(d) is misleading representation or any is a misrepresentation as to the financial condition of any insurer person, or as to the legal reserve system upon which any life insurer operates; or using

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or making any

(f) is a misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to the lapse, forfeiture, exchange, conversion, or surrender his of any insurance policy; or

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) FALSE INFORMATION AND ADVERTISING GENERALLY. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) DEFAMATION. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer any person, and which is calculated to injure any such person engaged in the business of insurance.

(4) BOYCOTT, COERCION AND INTIMIDATION. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in reasonable restraint of, or monopoly in, the business of insurance.

(5) FALSE FINANCIAL STATEMENTS AND ENTRIES.

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer a person with intent to deceive.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully person or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer person in any book, report or statement of such insurer person.

(6) STOCK OPERATIONS AND ADVISORY BOARD CONTRACTS. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind

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promising returns and profits as an inducement to insurance.

(7) UNFAIR DISCRIMINATION.

(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes ~~the above section,~~ this paragraph should be omitted.

(8) REBATES.

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in clause (7) or paragraph (a) of clause (8) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.

(9) UNFAIR CLAIM SETTLEMENT PRACTICES

Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

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

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) FAILURE TO MAINTAIN COMPLAINT HANDLING PROCEDURES. Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination under S. . This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this Subsection, "complaint" shall mean any written communication primarily expressing a grievance.

Drafting Note: Each state may wish to consider exempting agents and brokers from this Subsection.

(11) MISREPRESENTATION IN INSURANCE APPLICATIONS. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurers, agent, broker, or individual.

~~(9)~~ (12) Any violation of any one of Section

Drafting Note: Insert section numbers of any other sections of the Insurance Law which it is deemed desirable or necessary to include as an unfair trade practice.

SECTION 5. FAVORED AGENT OR INSURER; COERCION OF DEBTORS.

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(d) The (Commissioner), upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The (Commissioner), upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the (Commissioner) shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the court of county or the county where such party resides, on application of the (Commissioner), may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

(e) Statements of charges, notices, orders, and other processes of the (Commissioner) under this Act may be served by anyone duly authorized by the (Commissioner), either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same, and the return postcard receipt for such statement, notice, order or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

SECTION 7-8--CEASE AND DESIST AND PENALTY ORDERS AND MODIFICATIONS THEREOF.

(a) If, after such hearing, the (Commissioner) shall determine that the person charged has engaged in an unfair method of competition ~~or the act or practice in question is defined in section 4 and that the person complained of has engaged in such method of competition, act or practice in violation of this act, or on unfair or deceptive act or practice~~ he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of Sections 4 or 5, the (Commissioner) may at his discretion order any one or more of the following:

(A) payment of a monetary penalty of not more than \$1000 for each and every act or violation but not to exceed an aggregate penalty of \$10,000\* unless the person knew or reasonably should have known he was in violation of this Act, in which case the penalty shall be not more than \$5000 for each and every act or violation but not to exceed an aggregate penalty of \$50,000 in any six month period.\*

(B) suspension or revocation of the person's license if he knew or reasonably should have known he was in violation of this Act, or

(C) such other relief as is reasonable and appropriate.\*\*

(b) Until the expiration of the time allowed under section 9 of this Act for filing a petition for review (by appeal or writ of certiorari) if no such petition has been duly filed within such time or, if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the court, as hereinafter provided, the (Commissioner) may at any time, upon such notice and in such manner as he shall deem proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing such a petition for review if no such petition has been duly filed within such time, the (Commissioner) may at any time, after notice and opportunity for hearing, reopen and alter, modify or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest shall so require.

SECTION 8-9--JUDICIAL REVIEW OF CEASE AND DESIST ORDERS.

\* Material in italics added by the Laws, Legislation and Regulation (B) Committee.

\*\*This paragraph was deleted by the Law, Legislation and Regulation (B) Committee.

draft.

Section 4(1). Misrepresentations and False Advertising Of Insurance Policies. While we believe that the language of the Model Act was sufficient to cover many of the suggested changes, particularly those we have no objection to the proposed changes. Clauses (f) through (h) broaden the Model Act. These can be regarded as desirable additions. Certainly they are not objectionable.

Sections 4(2). False Information and Advertising Generally. and 4(3). Defamation. The proposed changes are mainly editorial and are not objectionable.

Section 4(5)(b). False Statements and Entries. The Model Act makes it an unfair practice to make false entries in, or fail to make true entries in, company books, etc., if done with the intent to deceive the regulator. The proposed changes would make it an unfair act to knowingly make (intent to deceive no longer being the test) false entries, or fail to make true entries, of material facts in company books, reports, etc. While we do not see the necessity for this change, so long as the section applies only with respect to material facts, the Industry Advisory Committee sees no reason to object to this change.

Section 4(8). Rebates. This subsection as contained in the Model Act is applicable only to life insurance, annuities and accident and health insurance. The draft before you proposes to enlarge the subsection so as to apply to all lines of insurance. We recommend that the change not be adopted. The Advisory Committee has consistently maintained that the Model Act should not contain provisions which duplicate other provisions in the insurance laws. In a state which has enacted the "Rebate" provision contained in the All-Industry Rating laws, the enlargement of this subsection would duplicate existing law and do so in such a way as to conflict with the existing law. It would also have the effect of imposing double penalties in many states, since the Model Act is not drafted so as to supercede existing law. For the state which does not have the "Rebate" provision of the All-Industry Rating laws, we recommend that such state adopt that provision rather than enlarge upon the provisions of the Model Unfair Trade Practices Act in the manner proposed here.

If the B-6 Subcommittee adopts this proposal it will essentially be taking an inconsistent position with respect to prior attempts to achieve reasonably uniform approaches to insurance legislation. The All-Industry Rating laws included provisions for treatment of rebates. In doing so it excepted certain lines of insurance that were not subject to rate regulatory control, such as wet marine, aviation and reinsurance where the rates are essentially case made. It also included appropriate language reflecting practices in the property and casualty business, where in some cases the actual premium is not always set forth in the policy but is contained in a rate filing. The proposed revision does not contain these exceptions and does not allow for the industry practices referred to. No need for this type of change has been demonstrated.

In addition, it seems surprisingly inconsistent to us that a provision of the Model Act which was included so as to treat life, health and annuity similarly to the treatment then already accorded other lines of insurance should, at this time, be modified to include those other lines of insurance. This is particularly inconsistent in light of the manner in which this revision is proposed.

One additional point deserves to be made. Clause (b) (iii) of the subsection makes reference to the readjustment of premiums for group insurance. As contained in the Model Act it clearly refers to group life and health insurance. The proposed revision would also seemingly include "group" auto and "group" property. At this stage of development in those fields we just do not know whether the language of that clause would be restrictive of practices that may be developed in those fields. It may unwittingly do so. The suggestion has been made that the clause ought to be amended so as to apply only to group life and group health. That is not an acceptable solution because the effect would be to prohibit retroactive rate adjustments for "group" casualty and property. This is just one more reason why the proposed revision should not be adopted.

Section 4(9). Unfair Claim Settlement Practices. This entire subsection is new material. In large part it contains provisions the substance of which has been enacted into law in several states, but not in unfair trade practice laws. The Industry Advisory Committee's draft also contains provisions substantially similar to a number of provisions in this draft, namely clauses (a), (b), (c), (f), (g), (h), (i), (k) and (l). There is however, some difference in language, which we will mention in our comments on the respective clauses:

1. In the prefatory language, we believe the phrase "without just cause and" ought to be inserted following the word "performing". This approach has been taken in a few states which have enacted provisions of this type. Since these are new standards, and particularly since monetary penalties can be imposed for violation



of the law, we believe it only fair that some allowance ought to be made for innocent violations in this area. It can be argued that the clause "with such frequency as to indicate a general business practice" negates the possibility of "just cause" becoming an issue. We are not that confident as to the impact of these standards upon our complex industry. Therefore we believe some allowance should be made in this area, particularly since its inclusion will not weaken the intent of the subsection. Certainly it is not the intent of the law to punish acts done with just cause. We refer you to clauses (e) and (g) as an example of the need for this language.

2. Clauses (d) and (e) of this draft are to an extent redundant with clauses (b) and (c). Clause (d) makes it an unfair trade practice to refuse to pay claims "without conducting a reasonable investigation based upon all available information." This language seems to require some investigation in all circumstances, even where the insurer's nonliability under the contract may be clear from the proofs of loss that have been submitted. It can be argued that the word "reasonable" would obviate the necessity for an investigation in those circumstances. We are not sure that is the case and, in any event, the language should be clear enough not to require this kind of interpretive process. It appears to us that this question could be avoided, and the subsection shortened by adding the phrase "and processing" after the word "investigation" in clause (c) of the subsection. Clauses (d) and (e) could then be eliminated since "processing" would include both payment of the claim or denial thereof.

In any event, if clause (e) is to be retained, we recommend that the word "statements" be deleted. Proofs of loss oftentimes require more than "statements." Certainly companies should not be put in a position where they have to act before the insured, claimant or beneficiary has completed the requirements imposed by the policy contract or by the nature of the claim. The deletion of the word "statements" removes the necessity of arguing whether a particular requirement is a "statement." In the parlance of the trade a proof of loss statement is very often considered to be the claim forms which are filed. These documents do not always contain the information necessary to determine whether to deny or affirm the claim.

3. As to clause (g) we recommend adding the language "when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered" following the word "insureds". One can only judge the reasonableness of the insurer's actions in compelling an insured to institute litigation in relation to the amount claimed by the insured, not by the amount recovered in a judgment. For example, if an insurer has offered \$25,000 in settlement of a claim and the court granted a verdict for \$40,000 that would seem to put the insurer in a position where it has violated the law. However, if the insured was asking \$100,000 to settle, the whole matter takes on a different perspective. The actions of the insurer become very reasonable in that context. Therefore we believe this clause ought to recognize the realities of the situation and not merely look at one-half the equation. Our suggested language solves that problem.

4. Clause (h) prohibits the practice of settling claims for less than the amount a reasonable man would believe he was entitled to by the written or printed advertising material that accompanied or was part of the application. Essentially this means that there was misleading advertising used. To that extent this clause is redundant to Section 4(1)(a) of the Act, as proposed for revision. Under the circumstances this practice ought more appropriately be included in regulations issued to identify practices prohibited by Section 4. While the Industry Advisory Committee draft contains a similar provision, upon further reflection we believe this clause ought to be deleted since its inclusion would appear to justify fines for violation of two provisions of the Act for the commission of the same practice or act. This does not seem appropriate to us.

5. Clause (j) imposes an obligation upon the insurer to tell the policyholder — and incidentally that should be changed to "insureds" for consistency with the other clauses — and beneficiary of the coverage under which payment is made. This may raise some practical problems because many claim payments are processed by computer and expense problems are presented if we must become very specific in this connection. Many policies have but one coverage, a life policy for example. The same is true in many forms of health coverages, such as major medical insurance. So there is no real necessity for some separate statement apart from the policy number itself. In those policies which have more than one coverage under which payment could be made, such as a med pay coverage and a property damage coverage in an auto policy, the coverages are often coded by number or letter in the policy itself. We presume that a reference to such code in the check or draft would be sufficient for purposes of this subsection. If so and if the subsection requires no more than that then we have no objection to the clause. If more is required then we repeat, we will be required to incur substantial additional expense, which must ultimately be borne by the policyholder.

Perhaps the best solution to this problem is to require such a statement to be given upon request by the insured or beneficiary. This would seem to remedy the problem for the public and would not create a problem for the insurers. This can be accomplished by re-wording clause (j) as follows:

"(j) failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;"

Section 4(10). Failure to Maintain Complaint Handling Procedures. The Industry Advisory Committee is somewhat surprised at the format of this subsection. We came away from our November 3rd meeting with the B-6 Subcommittee under the impression that the Advisory Committee's suggested language, augmented by a general requirement that a record of complaints be kept, would be included in this draft. Even though we still had many reservations about that kind of approach we thought it was not an unreasonable requirement and that we could live with it. This subsection is another matter entirely.

Our objection is not with the principle that an insurer ought to handle complaints promptly and reasonably, nor with the idea that we ought to keep records of these complaints for review by examiners. We are concerned however by attempts to create artificial requirements for the handling of complaints, such as separate departments, appointment of officers to supervise complaints and reports to the board of directors regarding complaints. These requirements totally ignore the realities of operating an insurer. They presume that all insurers are operated alike. They also presume that a chief executive officer is not going to be interested in handling complaints unless he has to report to the board of directors on the subject. These are not proper presumptions. Companies operate differently, some are regional, some are national. Each has procedures adapted to its own organization. Companies should not be forced into the kind of mold required by this subsection.

Our greatest problem lies, however, with the reporting requirement and the fact that the record of complaints is to be a public document. This reflects the totally erroneous idea that the number of complaints is a measure of how good a job a company is doing. Number of complaints is not a proper measure. The only proper measure is whether the complaint was justified. This cannot be determined by a statistical approach but only by reading the complaint file. This is the very reason why complaint files have been reviewed by examiners. The number of complaints received by an insurer may be a good starting point to determine whether an examiner ought to go in and review the operation. But as a number it is meaningless.

We are greatly concerned about the reporting requirement for a number of reasons. First and most obvious it is one more set of reports. While we have no objection to reports that have some meaning, we don't believe the kind of report this subsection contemplates is meaningful. Second, making such reports public documents can do great and improper harm to insurers. We know what will happen -- there will be a release as to the numbers that have been submitted by insurers. This release will compare the insurers statistically and those statistics will in no way reflect or make allowance for:

1. the premium volume by line of insurance;
2. the number of business transactions that produced the number of complaints;
3. The geographic area in which the respective insurers operate -- we all know that residents of large urban areas tend to be more contentious than residents of rural areas;
4. the method of operation of the insurer; that is, companies operation through independent agents may never receive the complaint. Their insureds tend to contract the writing agent not the company. This subsection makes no attempt to require that agents keep records of their complaints. Even if it did, how would the department determine the company to which to ascribe the complaint, if the action complained of was committed by an agent who engages in policy writing, premium collection or claim handling.
5. the fact that there is no way in which the department can be sure that records will be kept accurately. The very company that should be of concern to the department is the one which will not keep accurate records.

As a public record, we presume it would automatically be admissible in any hearing, relative to the insurer's operation. As we have already pointed out, such a record is not material or relevant.



## (8) REBATES.

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in clause (7) or paragraph (a) of clause (8) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

## (9) UNFAIR CLAIM SETTLEMENT PRACTICES.

Committing any of the following acts, if done without just cause and if performed with such frequency as to indicate a general business practice:

- a) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
- b) failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under insurance policies;
- c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- d) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear;
- e) compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;
- f) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- g) attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge or consent of insureds;
- h) attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to by written or printed advertising material accompanying or made part of an

application;

i) attempting to delay the investigation or payment of claims by requiring an insured and his physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

j) failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed;

k) refusing payment of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information.

(10) UNFAIR HANDLING OF COMMUNICATIONS BY INSURERS. Failing to adopt and implement reasonable standards for the prompt handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants.

(11) REFUSING TO INSURE RISKS. Refusing to insure risks solely because of race, color, creed or national origin.

(13)-~~(9)~~ Any violation of any one of Section . . . . . 1

#### SECTION 5 POWER OF COMMISSIONER.

The (Commissioner) shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

#### SECTION 6--HEARINGS, WITNESSES, APPEARANCES, PRODUCTION OF BOOKS AND SERVICE OF PROCESS.

(a) Whenever the (Commissioner) shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 4 and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than \_\_\_\_\_ days after the date of the service thereof.

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the (Commissioner) requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the (Commissioner) shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

(c) Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence.

(d) The (Commissioner), upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The (Commissioner), upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the (Commissioner) shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the court of \_\_\_\_\_ county or the county where such party resides, on application of the (Commissioner), may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

<sup>1</sup>Insert section numbers of any other sections of the Insurance Law which it is deemed desirable or necessary to include as an unfair trade practice.

Continued from page 16

hearing.

Territorial automobile rating would be eliminated in California under Assembly Bill 2041 by Assemblyman David Pierson (R) and Chairman of the Assembly Finance and Insurance Committee. Pierson has referred the measure for interim study without having it heard and indicated that he believes a study in depth of the issue is needed because of possible discrimination of existing automobile rating systems on minorities. The Insurance Department has engaged in past studies in connection with similar legislation in prior sessions and can be expected to update its data if such an interim study is undertaken.

Assemblyman Pierson has also authored Assembly Bill 459 which would establish a comprehensive unfair claim settlement practices regulatory measure patterned after a model bill developed by the National Association of Insurance Commissioners. After consultation with the industry, Pierson modified A.B. 459 to utilize a cease and desist approach rather than a substantial fine or suspension of certificate of authority sanction concept and as a result, the revised measure appears headed for final enactment.

Eight of the 22 Insurance Department legislative measures have reached the Governor's desk. These include Senate Bill 760 which would require the Department to collect an additional fee of \$5.00 where a check for payment of taxes, fees or penalties is dishonored, Senate Bill 761 restricting membership solicitation by a motor club agent, Senate Bill 843 authorizing the Department to use certified mail when directing an insurer to provide a certificate of acts, Senate Bill 844 revising life insurance incontestability provisions and Senate Bill 965 empowering the Department to use registered mail in serving notices on alien insurers. All are authored by Senator Clark Bradley (R), Chairman of the Senate Insurance and Financial Institutions Committee.

In addition, Assembly Bill 829 by Assemblyman Robert Beverly (R) would increase from ten to twelve percent the permissible proportion which organization expenses excluding accounting, actuarial and legal fees, may bear to the total amount actually paid for on capital stock of a newly formed domestic insurer, Assembly Bill 863 by Assemblyman Newton Russell (R) which clarifies provisions of the property cancellation and nonrenewal law of 1970 and Assembly Bill 992 by Assemblyman Carlos Moorhead (R) which requires every application for a production agency license to contain the names and addresses of all officers, directors and shareholders owning at least ten percent of the stock of such an agency.

Assemblyman Beverly has also authored Assembly Bill 1056, the Department's measure to establish a Life and Disability Guarantee Association similar

to the property and casualty post insolvency law enacted in 1969. Opposition from all segments of the life and disability insurance industry has prompted the Department to request that an interim study of the subject matter be made.

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