



Essential Protections for Policyholders



A project of
the Rutgers Center for Risk and Responsibility
at Rutgers Law School
in cooperation with United Policyholders

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About Essential Protections for Policyholders

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

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

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

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Introduction

Homeowners need to be able to buy good insurance coverage and understand what they are buying. When losses occur, insurance companies need to deliver on the protection they have promised. The Essential Protections for Policyholders project analyzes and recommends state laws that make sure that happens.



Homeowners insurance provides financial security. Fires, accidents, and storms may occur, but insurance provides funds to rebuild. Just as important, insurance provides emotional security; policyholders expect their insurance companies to be trusted partners in the process of coping with losses.

But policyholders' belief that insurance will provide security is not always met. Consumers are limited in their ability to shop effectively for insurance by a lack of information. Policies offered by some insurance companies may have gaps in coverage. Sometimes the policies offered by every company lack the complete coverage that policyholders need and expect. The promise of security can be frustrated by complex, confusing, and surprising terms in insurance policies. And when losses occur, disputes can arise between policyholders and their insurance companies about the extent of coverage under the policies and the scope and value of the losses.

To address these problems, homeowners insurance is heavily regulated by state law. Legislatures, insurance departments, and courts recognize that the market for insurance can be improved and that insurance carries an important public interest that requires legal regulation.

Every state regulates insurance and insurance companies, but states differ dramatically in how much and what kind of regulation they provide for the benefit of policyholders. The Essential Protections provide a roadmap that every state can follow in improving homeowners insurance. The Essential Protections also provide a scorecard to evaluate states' current systems of regulation and to identify areas for improvement.

The Essential Protections for Policyholders focus on the insurance needs of residential property users—homeowners, condominium owners, renters, and others—in four ways:

Essential Protections When Buying Insurance

Consumers need readily available, easily understandable information about the insurance policies available to them and the insurance companies that offer those policies in order to shop effectively for insurance. The Essential Protections aim to give consumers full, understandable information about insurance policies and insurance companies so that they can make wise buying decisions when shopping for insurance and when renewing insurance policies and to create competition among companies that leads to better products and fairer prices.

Essential Protections for Coverage

All homeowners need basic protection from their insurance policies and many would buy additional protection. The Essential Protections require that policies contain minimum guarantees of protection and that companies offer some kinds of additional protection. Policyholders also need to be protected against unfair cancellation or nonrenewal of their policies, and the Essential Protections set standards there, too.

Essential Protections in the Claims Process

The protection and security that an insurance policy provides must be most effective in the claims process. The Essential Protections require insurance companies to provide adequate information to insureds about the claims process and to establish and implement reasonable standards for processing, investigating, evaluating, and paying claims.

Essential Protections for Disaster Victims

Policyholders who suffer losses due to natural disasters such as hurricanes, wildfires, or tornadoes face all of the potential problems that other policyholders confront and more. Many of the Essential Protections for Policyholders that apply in other circumstances are extremely important for

disaster victims as well. Disaster victims also need more extensive protections because of the distinctive conditions created following disasters.

Executive Summary

RUTGERS
Center for Risk and Responsibility

Essential Protections for Policyholders

United
Policyholders
Empowering the Insured

Essential Protections When Buying Insurance

Consumers should have easily available, understandable information and tools for comparing coverage in insurance policies.

- Insurance departments should post online commonly used policy forms and comparisons of key policy provisions for consumers to view and compare.

Consumers should have easily available, understandable information about insurance companies' claim practices.

- Insurance departments should post online information about insurance companies' practices in paying claims for consumers to view and compare.

Policyholders should be given clear information about their own insurance policies.

- Insurance policies and notices to policyholders should be clearly organized and written in plain language.
- Insurance companies must give to applicants for insurance and policyholders at the time of renewal clear explanations of key policy terms, significant limitations and exclusions, the need for and availability of additional insurance for natural disasters, and any new and altered policy terms in the case of renewal.

Essential Protections for Coverage

Homeowners' insurance policies should contain minimum guarantees of protection and insurance companies should offer essential additional coverages.

- Every homeowner's insurance policy should contain essential terms and coverage, and policyholders at the time of purchase or renewal should be able to purchase additional important coverage.

Insurance companies must observe reasonable standards for canceling and renewing policies and reporting claims.

- Insurance companies may not use an inquiry about a loss or a single claim as the basis for cancellation, nonrenewal or premium increase of a policy.

Essential Protections in the Claims Process

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

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

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

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

Insurance companies must observe reasonable standards in the claim process.

- Insurance companies must promptly, fairly, and objectively process, investigate, evaluate, and resolve claims.
- Insurance companies must observe reasonable standards for determining the amount of loss.
- Policyholders should have access to efficient, effective means of dispute resolution.
- Insurance companies must not unreasonably pressure policyholders to settle claims.

Policyholders must have effective remedies if insurance companies act unreasonably.

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

Essential Protections for Disaster Victims

Disaster victims should have flexibility in coverage provisions and the claims process.

- Policyholders after disasters should have a reasonable time for additional living expense and for filing claims.

Disaster victims should have clear rules about causes of loss to avoid unfair gaps in coverage.

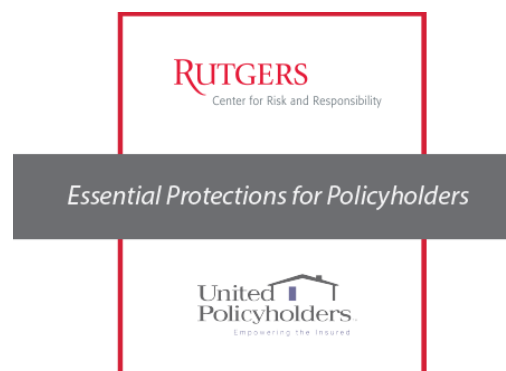
- Policyholders should be compensated for losses due to covered causes.

Disaster victims should be protected against sudden dislocations in the insurance market.

- Insurance companies may not decline, cancel, nonrenew, surcharge, or increase premiums because of disasters.

Essential Protections When Buying Insurance

Homeowners need readily available, easily understandable information about the insurance policies available to them and the insurance companies that offer those policies in order to shop effectively for insurance. Insurance companies mostly provide only one kind of information—price. Statutes, regulations, and administrative action are needed to provide consumers with more and better information. Giving consumers full, understandable information about insurance policies and insurance companies enables them to make wise buying decisions when shopping for insurance and when renewing insurance policies, and it creates competition among companies that leads to better products and fairer prices.



Consumers should have easily available, understandable information and tools for comparing coverage in insurance policies.

- **Insurance departments should post online commonly used policy forms and comparisons of key policy provisions for consumers to view and compare.**

Insurance is the only product for which consumers do not know what they are buying before they buy it. Insurance companies almost never provide copies of policy language or complete summaries of policy terms to prospective policyholders. Because policies are complex legal documents that vary widely among companies in what they cover and what they don't cover, consumers need ready access to policy forms and comparisons of key provisions to shop carefully for insurance.

Because most consumers won't read long, complex insurance policies before buying, a convenient comparison of key terms is essential. An example in the health insurance context is the Summary of Benefits and Coverage mandated by the Affordable Care Act and developed by state insurance regulators; the Summary answers in a clear format questions such as "What is the overall deductible?" and "Do I need a referral to see a specialist?"¹ In homeowners insurance the policy comparison tool terms should include information such as

- Whether the policy is Named Perils or All-Risk;
- Whether coverage is Actual Cash Value, Replacement Cost, Extended Replacement Cost, or Guaranteed Replacement Cost;
- Whether the policy covers damage from flood, earthquake, windstorm, or other catastrophic causes, and whether other insurance is available for such losses from such causes.
- Whether the policy contains special deductibles such as a Hurricane Deductible.
- Whether the policy contains Law and Ordinance or Building Code Upgrade coverage, and, if not, whether such coverage is available at an additional cost.
- The extent of Additional Living Expense coverage.

The tool also should contain links to easily understandable explanations of the key terms.

The publication of policies would encourage better shopping by consumers. It also would encourage the development of concise ratings of different policies by consumer groups and websites as occurs in the United Kingdom, where the consumer organization Which? provides numerical ratings and five-star rankings of insurance policies and insurance companies.²

Recommended action:

Insurance departments should make available online residential property policy forms of all insurance companies doing business in the state, or at least those companies that have a significant market share based on direct premiums written.

¹ <https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/>

² <http://www.which.co.uk/money/insurance/>

Insurance departments should prepare and post online a policy comparison tool that enables consumers easily to compare key terms of insurance policies.

Current law:

Insurance departments in practically every state already have sufficient legal authority to take these steps. Insurance companies are required to file policy forms with and typically have them approved by insurance departments. Although policies may be subject to copyright, departments in the exercise of their regulatory authority may publish the forms for the use of consumers.

Several states already publish policy forms online, typically for the insurer groups having the largest market share or a significant market share by direct premiums written in the state. See, for example, the websites of the Maine, Missouri, Nevada, Oklahoma, and Texas insurance departments. The Texas Insurance Department HelpInsure Home page provides comparisons of some key policy terms.

The National Association of Insurance Commissioners (NAIC) currently has a Transparency and Readability of Consumer Information Working Group. The charge of the Working Group is to “Study and evaluate actions that will improve the capacity of consumers to comparison shop on the basis of differences in coverage provided by different insurance carriers.”³

Consumers should have easily available, understandable information about insurance companies’ claim practices.

- **Insurance departments should post online information about insurance companies’ practices in paying claims for consumers to view and compare.**

Quality is an important attribute of any product, including insurance. The two measures of quality for insurance are insurance companies’ financial stability and their record of paying claims promptly and fairly. State insurance departments generally do a good job of monitoring companies’ financial stability, and easy-to-understand ratings are produced by ratings agencies such as A.M. Best and are widely available. Claim

³ http://www.naic.org/committees_c_trans_read_wg.htm ;
http://www.naic.org/cipr_topics/topic_transparency_readability.htm .

practices are not closely regulated and the information on which consumers can compare companies is not publicly available. An Essential Protection is to provide current, helpful statistics with which consumers can compare companies as to how promptly and fairly they pay claims. These statistics are now reported by companies to insurance departments and include, by year:

- Number of claims opened, closed with payment, and closed without payment.
- Median days to final payment.
- Number of claims closed with and without payment within 0-30 days, 31-60 days, and so on.
- Number of suits by policyholders opened and closed.

Insurance departments also should create online tools that facilitate comparison of different companies, such as ratios of claims closed with and without payment to claims opened, by company and jurisdiction-wide. Information about consumer complaints and regulatory actions including market conduct examinations also should be readily available to consumers.

Recommended action:

Insurance departments should publish online on an annual basis data about individual insurance companies' claim practices and tools for comparing information about different companies.

Insurance departments should post online information about nonrenewals, consumer complaints, market conduct examinations, and other regulatory actions.

Recommended statutory language:

Notwithstanding the provisions of subsection [] of this section or of any other law to the contrary, in order to assist in the performance of the commissioner's duties, the commissioner may:

...

(4) Use documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, communications, or information to provide to consumers information on insurers' claims practices, by insurer by line of insurance, including, without limitation:

- a) relevant information equivalent to that provided on the Market Conduct Annual Statement; and
- b) annual ratios of:
 - i) claims unprocessed to claims filed or pending;
 - ii) claims closed without payment to claims closed;
 - iii) claims closed within specified time periods;
 - iv) non-renewals to policies in force;
 - v) cancellations by specified time periods to policies in force; and
 - vi) suits opened to claims closed without payment.⁴

Current law:

Most states already collect this data and report it to the NAIC, which aggregates it and reports it in limited form to insurance companies. The NAIC Market Conduct Surveillance Model Law (MDL-693) § 7 and the National Conference of Insurance Legislators' Market Conduct Annual Statement Model Act § 8 provide that claims data reported to or collected by the department are privileged and confidential. The NAIC Model Law has been adopted in substantially the same form in many states.⁵ Other states have statutes in different form that are similar in effect.⁶ The recommended statutory language removes that confidentiality and requires insurance commissioners to make the data available.

Policyholders should be given clear information about their own insurance policies.

- **Insurance policies and notices to policyholders should be clearly organized and written in plain language.**

⁴ This language would amend Section 7.D. of the NAIC Market Conduct Surveillance Model Law (MDL-693) (October 2004). Variations in state adoptions would require appropriate changes.

⁵ E.g., Ariz. Rev. Stat. Ann. § 20-158; Haw. Rev. Stat. § 431:2D-107; Ohio Rev. Code Ann. § 3916; R.I. Gen. Laws Ann. § 27-71-8; Wash. Rev. Code Ann. § 48.37.080.

⁶ E.g., Ga. Code Ann. § 33-2-14.

Insurance policies are complex legal documents. A typical homeowners' insurance policy will run for dozens of pages with definitions, terms of coverage, exclusions, exceptions, conditions, and more. For a policyholder to evaluate a policy being considered for purchase, to determine whether to file a claim, or to resolve a dispute with an insurance company, the policy must be clearly organized and written in plain, non-technical language.

Recommended action:

States should require insurance policies to conform to minimum standards of organization, presentation, and readability. At a minimum, the standards should prescribe that policies:

- Use clear layout, font, headings, spacing, and other measures of legibility.
- Meet defined tests for readability and plain language.
- Contain a table of contents and index.

Current law:

Many jurisdictions have Plain Language laws governing insurance policies. The NAIC's Property and Casualty Insurance Policy Simplification Act (MDL-730) sets a general standard requiring that policies be "simplified, taking into consideration the following factors:"

- A. Use of simple sentence structure and short sentences;
- B. Use of commonly understood words;
- C. Avoidance of technical legal terms wherever possible;
- D. Minimal reference to other sections or provisions of the policy;
- E. Organization of text; and
- F. Legibility.

The implementing Model Regulation (MDL-731) adds requirements such as a table of contents, self-contained sections, legibility, and a minimum score on the Flesch Reading Ease Test of 40. The use of a Flesch score as a test of readability is common.⁷ Other

⁷ E.g., Colo. Rev. Stat. Ann. § 10-4-110.8 (fifty, or tenth-grade reading level); Conn. Gen. Stat. Ann. § 38a-297 (forty-five); Fla. Stat. Ann. § 627.4145 (forty-five); Tex. Ins. Code Ann. § 2301.053 (minimum score established by the insurance commissioner).

typical requirement include avoiding “unnecessarily long, complicated, or obscure words, sentences, paragraphs, or constructions,”⁸ “sentences that contain double negatives and exceptions to exceptions [and] sentences and sections that are in a confusing or illogical order.”⁹

The NAIC Transparency and Readability of Consumer Information Working Group is considering changes to the Model Regulation and related regulations including new readability rules, promoting consistent, clear and logical formatting and organization of all policies, and other measures to “facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.”¹⁰

- **Insurance companies must give to applicants for insurance and policyholders at the time of renewal clear explanations of key policy terms, significant limitations and exclusions, the need for and availability of additional insurance for natural disasters, and any new and altered policy terms in the case of renewal.**

Even insurance policies that are well-organized and readable often will not be read or understood by consumers because the policies are necessarily long and complex and because consumers are likely to not pay attention to the details of their policies until they have a potential claim. Therefore, applicants and policyholders need to be provided accessible summaries of the terms that are likely to be most important to them. At the time of renewal, policyholders especially need to be informed about changes in terms. Some of the most important terms are common to all homeowners and others will vary among the states. The information should be provided in a standardized form prescribed by the state and should contain at least the following information, with understandable explanations of each:

- A simple explanation of the major coverages and exclusions of the policy.
- In the case of a renewal, any changes in terms or premium.
- Whether the policy is Named Perils or All-Risk;
- Whether coverage is Actual Cash Value, Replacement Cost, Extended Replacement Cost, or Guaranteed Replacement Cost;

⁸ Conn. Gen. Stat. Ann. § 38a-297(a); Fla. Stat. Ann. § 627.4145(1)(d).

⁹ N.J. Stat. Ann. § 56:12-10(a).

¹⁰ http://www.naic.org/cipr_topics/topic_transparency_readability.htm .

- Whether the policy covers damage from flood, earthquake, windstorm, or other catastrophic causes, and whether other insurance is available for such losses from such causes.
- Whether the policy contains special deductibles such as a Hurricane Deductible.
- Whether the policy contains Law and Ordinance or Building Code Upgrade coverage, and, if not, whether such coverage is available at an additional cost.
- That the policy contains time limitations for Additional Living Expense and for providing notice of loss, filing claims, repairs to be completed, and a claim to be adjusted.

Recommended action:

States should require that at the time of application, issuance of a policy, and renewal, insurance companies must furnish to policyholders, in a standardized form prescribed by the state, essential and easily understandable information about the terms of the policy.

Current law:

Many states require notifications that include some of this information. For example:

- A simple explanation of the major coverages and exclusions of the policy.¹¹
- In the case of a renewal, any changes in terms or premium.¹²
- Whether the policy is Named Perils or All-Risk;
- Whether coverage is Actual Cash Value, Replacement Cost, Extended Replacement Cost, or Guaranteed Replacement Cost;¹³
- Whether the policy covers damage, from flood, earthquake, windstorm, or other catastrophic causes, and whether other insurance is available for such losses from such causes.¹⁴

¹¹ La. Rev. Stat. Ann. 22:1332.

¹² Colo. Rev. Stat. §10–4–110.8(9).

¹³ Cal. Ins. Code § 10101; La. Rev. Stat. Ann. 22:1332.B(3); S.C. Code Ann. § 38-75-755.

- Whether the policy contains special deductibles such as a Hurricane Deductible.¹⁵
- Whether the policy contains Law and Ordinance or Building Code Upgrade coverage, and, if not, whether such coverage is available at an additional cost.¹⁶
- That the policy contains time limitations for providing notice of loss, filing claims, repairs to be completed, and a claim to be adjusted.¹⁷
- That the policyholder should read the policy for complete details and that the summary notification does not replace any provision of the policy.¹⁸

¹⁴ Cal. Ins. Code § 10081; N.J. Stat. Ann. § 17:36-5.38; La. Rev. Stat. Ann. 22:1332.B(2); S.C. Code Ann. § 38-75-755.

¹⁵ La. Rev. Stat. Ann. 22:1332.B(6); N.Y. Ins. Law § 3445.

¹⁶ Cal. Ins. Code § 10101; Colo. Rev. Stat. § 10-4-110.8(6)(a).

¹⁷ S.C. Code Ann. § 38-75-755.

¹⁸ Colo. Rev. Stat. Ann. § 10-4-111.

Essential Protections for Coverage

Homeowners insurance is not “one size fits all;” homeowners differ in what kind of insurance they need, want, or are willing to pay for. But all homeowners need certain basic coverage and should have the opportunity to purchase other coverage that is best suited to them. That way, homeowners can be informed about the choices available and can make better decisions about how much insurance of what kind to buy.

The most important element of coverage is a homeowner’s ability to use the coverage when it is needed. An Essential Protection is to make sure that policyholders are not discouraged from filing claims or punished for doing so by having their policies canceled or not renewed because they have asked about a potential claim or filed a claim.



Homeowners’ insurance policies should contain minimum guarantees of protection and insurance companies should offer essential additional coverages.

- **Every homeowner’s insurance policy should contain essential terms and coverage, and policyholders at the time of purchase or renewal should be able to purchase additional important coverage.**

Homeowners’ insurance policies vary greatly and insurance consumers reasonably can choose to buy different types of coverage depending on their economic circumstances and their willingness and ability to accept risk. But for homeowners’ insurance to serve its purpose of providing basic financial security, every homeowners’ policy should

include minimum essential terms, and consumers should be offered additional terms that address risks that are commonly encountered if a loss occurs.

Homeowners' policies typically include coverage for loss of use of the property, of which the most important component is Additional Living Expense (ALE). ALE coverage reimburses the homeowner for losses caused by the primary residence being uninhabitable, such as the cost of renting a comparable property. Because repairs can take time, policies should provide a minimum time period of twelve months during which ALE may be incurred; homeowners who wish additional protection should be able to purchase ALE coverage that extends for an additional twelve months.

Replacement cost coverage pays for the cost to repair or replace damaged property. If a homeowner chooses to rebuild or relocate at another location, the benefits of the policy still should be available, limited to the cost of replacement at the original location.

Replacement cost coverage typically is capped at a dollar amount stated in the policy limit. Extended Replacement Cost coverage provides an additional percentage that may be recovered. This protection is necessary if the estimate of the cost to repair that is the basis for the policy limit—often provided by the insurance company—is too low, and is especially important after catastrophes, when the cost of labor and materials typically rises.

Repair or rebuilding of damaged property often requires that the property be improved from its prior condition because building codes have changed since the original construction. A damaged property must be repaired or rebuilt to conform to the current building code which may require additional expense. Policyholders with Replacement Cost coverage reasonably expect that this additional cost will be part of their policy, and policyholders with Actual Cash Value coverage should be made aware of the need for so-called "Law and Ordinance Upgrade" coverage.

The Essential Protections apply to every homeowners' insurance policy. Individual states may have special situations that call for other essential terms or the offer of other additional coverage.

Recommended action:

States should require that every homeowners insurance policy contain essential terms and coverage and that insurance companies at the time of purchase or renewal offer additional coverage. These terms include:

- Minimum coverage for Additional Living Expense and the opportunity to purchase greater coverage.

- In a Replacement Cost policy, the opportunity to purchase coverage for Extended Replacement Cost, or the cost of replacement beyond the stated policy limit.
- In a Replacement Cost policy, Law and Ordinance coverage, or coverage for repair or replacement upgrades required by law.
- In an Actual Cash Value policy, the opportunity to purchase Law and Ordinance coverage, or coverage for repair or replacement upgrades required by law.

Recommended statutory language:

(1) Every homeowners insurance policy must include additional living expense coverage. This coverage must be available for a period of at least twelve months and is subject to other policy provisions. Insurers shall offer policyholders the opportunity to purchase a total of at least twenty-four months of additional living expense coverage.

(2) In the event of a total loss of a structure insured under a homeowners insurance policy that provides for replacement cost, the insured may rebuild or replace the property at a location other than the insured premises. In that case, the measure of indemnity shall be based upon the replacement cost of the insured property and shall not be based upon the cost to repair, rebuild, or replace at a location other than the insured premises.

(3) Before issuing or renewing a replacement cost homeowners insurance policy whose dwelling limit is equal to or greater than the estimated replacement cost of the residence, the insurer shall make available to an applicant the opportunity to obtain extended replacement-cost in an amount of insurance that is at least twenty percent of the limit of the insurance for the dwelling.

(4) Every homeowners insurance policy that provides for replacement cost shall include law and ordinance coverage for costs necessary to meet applicable laws and ordinances regulating the construction, use, or repair of any property or requiring the tearing down of any property, including the costs of removing debris. However, additional costs necessary to meet applicable laws and ordinances may be limited to 25 percent or 50 percent of the dwelling limit, as selected by the policyholder, and such coverage applies only to repairs of the damaged portion of the structure unless the total damage to the structure exceeds 50 percent of the replacement cost of the structure.

(5) Before issuing or renewing a homeowners insurance policy that provides for payment of losses at actual cash value, the insurer shall offer law and ordinance

coverage for costs necessary to meet applicable laws and ordinances regulating the construction, use, or repair of any property or requiring the tearing down of any property, including the costs of removing debris. However, additional costs necessary to meet applicable laws and ordinances may be limited to 25 percent or 50 percent of the dwelling limit, as selected by the policyholder, and such coverage applies only to repairs of the damaged portion of the structure unless the total damage to the structure exceeds 50 percent of the replacement cost of the structure.

Current law:

A few states specify by statute required ALE coverage.¹⁹ The ability to replace property at a different location is specified by statute in California²⁰ and by judicial interpretation of the insurance policy in other states.²¹ Several states require insurers to offer extended replacement cost and law and ordinance coverage.²²

Insurance companies must observe reasonable standards for canceling and renewing policies and reporting claims.

- **Insurance companies may not use an inquiry about a loss or a single claim as the basis for cancellation, nonrenewal or premium increase of a policy.**

Insurance companies legitimately can use some elements of policyholders' claims experience in deciding whether to issue or renew policies and how to price them. However, companies should not be able to use elements that are not strongly correlated with future risk or that discourage policyholders from pursuing legitimate claims. This practice—"use it and lose it"—makes some consumers uninsurable and, as knowledge of the practice becomes widespread, deters many others from asserting their rights. The most extreme version of this practice occurs when companies refuse to insure or renew

¹⁹ E.g., Colo. Rev. Stat. Ann. § 10-4-110.8; Md. Code, Insurance § 19-208.

²⁰ Cal. Ins. Code § 2051.5(c).

²¹ E.g., Huggins v. Hanover Ins. Co., 423 So. 2d 147 (1982); Blanchette v. York Mutual Ins. Co., 455 A.2d 426 (Me. 1983).

²² Colo. Rev. Stat. § 10-4-110.8(6)(a); Fla. Stat. Ann. § 627.7011.

or impose a premium increase or surcharge on policies merely because policyholders have inquired about coverage without actually filing a claim. The problem is made worse by companies' reliance on centralized databases about policyholders, so the fact that policyholders made inquiries are reported to all companies, even if the inquiries were unrelated to actual losses.

Recommended action:

States should prohibit insurance companies from refusing to issue, cancelling, surcharging increasing premiums, or refusing to renew policies because policyholders have made inquiries about coverage or potential claims or have filed one or a small number of claims.

Recommended statutory language:

- (1) An insurer shall not refuse to issue, refuse to renew, or cancel an insurance policy, establish rates for coverage, or impose a surcharge based in whole or in part on one or more inquiries made by any consumer to an insurer, regardless of the source of the information that inquiries were made.
- (2) An insurer shall not submit to any insurance support organization or consumer reporting agency that an inquiry was made to the insurer.
- (3) An "inquiry" means any communication to an insurance company by an insured, or by an insurance producer on behalf of an insured, regarding terms and conditions of a homeowners insurance policy, including a communication concerning whether a homeowners insurance policy provides coverage for a type of loss or the process for filing a claim, that does not result in the filing of a claim.
- (4) An insurer shall not cancel, refuse to renew, impose a surcharge on, or increase the premium of a homeowners insurance policy solely on the basis of
 - (a) claims made for coverage under the policy, unless two or more such claims have been made against the policy during the 36 months immediately preceding the expiration of the current policy period; or
 - (b) claims closed without payment, notwithstanding any other provision of this section.
- (5) An insurer shall not cancel a homeowner's policy of insurance or increase the policy deductible except for any of the following reasons:
 - (a) Nonpayment of premium.

(b) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured.

(c) Discovery of fraud or material misrepresentation by the named insured or his representative in obtaining the insurance or pursuing a claim under the policy.

(d) Discovery of grossly negligent acts or omissions by the insured or his or her representative substantially increasing any of the hazards insured against.

(6) An insurer shall not cancel or refuse to renew a policy except by notice to the insured. A notice of intention not to renew is not effective unless received by the named insured at least 30 days prior to the expiration date of the policy. Like notice must also be given to any party named as mortgagee on the policy. The notice must include the insurer's actual reason for refusing to renew the policy. The statement of reason must be explicit and sufficiently specific to convey, clearly and without further inquiry, the basis for the insurer's cancellation or failure to renew. Explanations such as "underwriting reasons," "underwriting experience," "loss record," "location of risk," "credit report" and similar terms are not by themselves acceptable explanations.

Current law:

A number of states have adopted statutes that limit insurance companies' ability to use inquiries as the basis of underwriting decisions.²³ The statutes typically are limited to homeowners' or other property insurance.²⁴ The definitions of "inquiry" vary modestly, usually including the two elements of "a request for information regarding the terms, conditions, or coverages offered under a property and casualty insurance policy" and that the inquiry "does not result in a claim."²⁵ The statutes prohibit the use of inquiries in specific situations, such as canceling or nonrenewing policies;²⁶ issuing or declining

²³ E.g., Ariz. Rev. Stat. Ann. § 20-1652; Colo. Rev. Stat. Ann. § 10-4-110.8; Del. Code Ann. tit. 18, § 4131;

Haw. Rev. Stat. § 431:10E-124; Minn. Stat. Ann. § 65A.285; Mont. Code Ann. § 33-15-1105; N.J. Stat. Ann. § 17:29B-4.1; Tenn. Code Ann. § 56-7-113; Tex. Ins. Code Ann. § 544.553; Tex. Ins. Code Ann. § 551.113; Wyo. Stat. Ann. § 26-23-108.

²⁴ E.g., Haw. Rev. Stat. § 431:10E-124; N.J. Stat. Ann. § 17:29B-4; Tex. Ins. Code Ann. § 551.113.

²⁵ E.g., Mont. Code Ann. § 33-15-1105. At least one state, Hawaii, narrows the definition by excluding inquiries where "the inquiry provides information not previously disclosed by the insured." Haw. Rev. Stat. § 431:10E-124.

²⁶ E.g., Colo. Rev. Stat. Ann. § 10-4-110.8.

to issue, nonrenewing, or canceling;²⁷ imposing surcharges or higher premiums;²⁸ or, most generally, “for purposes of making underwriting decisions.”²⁹ Some states also specifically prohibit insurance companies from reporting inquiries to national databases such as CLUE.³⁰

A number of states limit insurance companies’ ability to cancel or refuse to renew policies except for the reasons stated in paragraph (5) of the recommended statutory language.³¹ With reference to the “use it and lose it” concept, the most relevant language prohibits adverse action unless there is an event such as “a material change in the risk being insured”³² or “increased hazard or material change in the risk assumed that could not have been reasonably contemplated by the parties at the time of assumption of the risk.”³³ Some states specify a minimum number of claims that may trigger cancellation or nonrenewal.³⁴

Many states also have related provisions limiting the use of losses due to catastrophes or other weather-related events as a basis for cancellation, nonrenewal, or other underwriting decisions. Refer to the discussion under Essential Protections for Disaster Victims.

²⁷ E.g., Tex. Ins. Code Ann. § 551.113.

²⁸ E.g., Minn. Stat. Ann. § 65A.285; Wyo. Stat. Ann. § 26-23-108.

²⁹ Del. Code Ann. tit. 18, § 4131.

³⁰ E.g., Ariz. Rev. Stat. Ann. § 20-1652; Colo. Rev. Stat. Ann. § 10-4-110.8; Mont. Code Ann. § 33-15-1105.

³¹ E.g., Okla. Stat. Ann. tit. 36, § 3639.1; La. Rev. Stat. Ann. 22:1333; La. Rev. Stat. Ann. 22:1265; Tex. Ins. Code Ann. § 551.107 nonrenewal only if three or more claims in any three-year period); N.C. Gen. Stat. Ann. § 58-41-15; Ark. Code Ann. § 23-66-206); Wyo. Stat. Ann. § 26-35-202.

³² La. Rev. Stat. Ann. 22:1265(D).

³³ N.C. Gen. Stat. Ann. § 58-41-15(a)(3).

³⁴ E.g., La. Rev. Stat. Ann. 22:1265; Tex. Ins. Code Ann. § 551.107(d).

Essential Protections in the Claims Process

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



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

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

Policyholders are required to provide complete, accurate, and timely information in order to have their claims paid. Insurance companies have an obligation to assist policyholders in this process by giving them the information they need about policy terms, time limits, and other requirements for pursuing their claims, and information

the companies have received or developed about the claims. Many of these obligations are defined in detail in state adoptions of the NAIC's Unfair Claims Settlement Practices Act (UCSPA) and Model Regulation.³⁵

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

Recommended action:

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

Recommended statutory language:

- (1) The insurer shall provide to every claimant:
 - (a) A copy of [relevant state statutes and regulations concerning claim practices, such as the UCSPA].
 - (b) Forms necessary to present claims.
 - (c) Explanation of time limits applicable to the claim, including time limits for filing the claim and other time limits stated in the policy or by operation of law.
 - (d) Explanation of the claimant's rights in the event of a dispute, including mediation and appraisal.
 - (e) Explanation of the availability and procedures for filing a complaint with the state insurance department.
- (2) The insurer shall notify every claimant that they may obtain, upon request, copies of claim-related documents. Within fifteen calendar days after receiving a request from an insured for claim-related documents, the insurer shall provide

³⁵ E.g., UCSPA § 4.M.

the insured with copies of all claim-related documents, except those excluded by this section.

(a) For purposes of this section, “claim-related documents” means all documents that relate to the evaluation of loss, including, but not limited to, repair and replacement estimates and bids, appraisals, scopes of loss, reports, findings, drawings, plans, valuation, measurements, calculations, and all other information on the cause or amount of loss, covered damages, and cost of repairs. However, attorney work product and attorney-client privileged documents and documents that contain medically privileged information are excluded from the documents an insurer is required to provide pursuant to this section to a claimant.

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

Current law:

Section 4.M of the UCSPA, adopted in some version in many states, requires insurers “to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanation regarding their use.” Other state laws impose similar duties to provide information about aspects of the claim process.³⁶

The duty to provide a copy of the claim file on request is specifically mandated in California Insurance Code § 2071.³⁷ Even in states in which there is no specific statutory mandate, insurance companies are under a duty under the UCSPA and Model Regulation to provide relevant information and assistance to policyholders. Standards of reasonableness defined by courts similarly require insurance companies to be forthcoming with their policyholders.³⁸ In claim practices litigation the claim file is routinely available to policyholders in discovery.³⁹ The same information should be available to policyholders without the need to resort to litigation. Attorney work product, attorney-client privileged, and medically privileged documents are excluded, although those exclusions should be defined narrowly because “the payment or rejection of claims is a part of the regular business of an insurance company [so that]

³⁶ E.g., Cal. Ins. Code § 10103.

³⁷ A similar requirement is contained in La. Rev. Stat. Ann. § 22:41.

³⁸ E.g., *Bowler v. Fidelity & Cas. Co. of NY*, 250 A.2d 580 (N.J. 1969).

³⁹ See *Genovese v. Provident Life & Accident Ins. Co.*, 74 So. 3d 1064, 1068 (Fla. 2011); *Stewart v. Siciliano*, 2012-Ohio-6123, ¶ 44, 985 N.E.2d 226, 234; *Cedell v. Farmers Ins. Co. of Washington*, 295 P.3d 239, 245 (Wash. 2013); 2-16 New Appleman Insurance Bad Faith Litigation § 16.02; 2 Law and Practice of Insurance Coverage Litigation § 17:62 (2014).

reports prepared by insurance investigators, adjusters, or attorneys before the decision is made to pay or reject a claim are thus not privileged and are discoverable.”⁴⁰

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

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

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

Recommended action:

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

Recommended statutory language:

⁴⁰ Melworm v. Encompass Indem. Co., 977 N.Y.S.2d 321, 323 (App. Div. 2013).

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

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

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

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

Current law:

The NAIC Model Regulation § 5.D., adopted in a number of states,⁴¹ provides that “No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition, or claimant’s failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant’s duty to cooperate with the insurer.” The language “unless the written notice is a written policy condition” has the effect of permitting insurance companies to act unreasonably simply by including a

⁴¹ E.g., Ok. Admin. Code § 365:15-3-4; Ohio Admin. Code § 3901-1-54; Pa Code § 146.4; 14 Va. Admin. Code § 5-400-40.

boilerplate condition in the policy, even when the failure to give notice or file a proof of loss does not prejudice their interests. Other states remove the insurance companies' ability to rely on policy language in this way, and those laws are the basis of the recommended language.⁴²

All states have statutes of limitations limiting the time within which actions may be brought. Many states also have statutes that apply specifically to insurance policies, often based on the New York Standard Fire Policy (referred to in the industry as "the 165 lines" for its length in the statute), that requires the inclusion in policies of a provision that actions be "commenced within twenty-four months next after inception of the loss."⁴³ Many states also have statutes prohibiting and making unenforceable a provision in an insurance policy that attempts to shorten the period prescribed by the statute of limitations.⁴⁴ In the absence of a statute, courts generally hold that insurance policy terms attempting to shorten the period prescribed by the statute of limitations are disfavored but they are enforceable if they are reasonable.⁴⁵ A provision is reasonable "if it provides the insurer with prompt notice of the claim, yet allows the insured sufficient time after the rejection of the claim to investigate the claim and bring the action."⁴⁶ Even if a provision is reasonable, because of the special nature of insurance contracts courts often hold that such a provision may be enforced only if the insurer can demonstrate prejudice by the delay.⁴⁷

Replacement cost provides the cost to repair or replace without deduction for depreciation. Policies typically provide for payment of actual cash value until the policyholder completes replacement. The time requirement in the recommended statutory language is based on the California statute.⁴⁸

Insurance companies must observe reasonable standards in the claim process.

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

⁴³ N.Y. Ins. Law § 3404; see also Or. Rev. Stat. § 743.660; R.I. Gen. Laws § 27-5-3..

⁴⁴ E.g., Ariz. Rev. Stat. Ann. § 20-1115; La. Rev. Stat. Ann. § 22:868; Md. Code, Insurance, § 12-104; Neb. Rev. Stat. § 44-357; W. Va. Code § 33-6-14.

⁴⁵ E.g., McDonnell v. State Farm Mut. Auto Ins. Co., 299 P.3d 715 (Alaska 2013); City of Hot Springs v. Nat'l Surety Co., 531 S.W.2d 8, 10 (1975); Auto-Owners Inc. Co. v. Hughes, 943 N.E.2d 432 (Ind. App. 2011).

⁴⁶ Davis v. State Farm Fire & Cas. Co., 545 F. Supp. 370, 371-72 (D. Nev. 1982).

⁴⁷ Estes v. Alaska Guar. Ins. Co., 774 P.2d 1315 (Alaska 1989); Zuckerman v. Transamerica Ins. Co., 650 P.2d 441 (Ariz. 1982).

⁴⁸ Cal. Ins. Code § 2051.5.

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

The basic requirement for insurance companies when handling claims is that they must act reasonably. No insurance company would be willing to advertise its policies on any other basis, and no prospective policyholder would buy a policy on any other basis. Reasonableness does not demand perfection; everyone makes mistakes, including insurance companies. Reasonableness does demand that insurance companies adhere to widely accepted industry standards of performance and conform to the reasonable expectations of policyholders.

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

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

Recommended action:

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

Recommended statutory language:

(3) It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this act if:

~~A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder, or~~

~~B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.~~

(4) Any of the following acts by an insurer, ~~if committed in violation of Section 3,~~ constitutes an unfair claims practice.

Current law:

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

The UCSPA has been adopted in nearly every state, although individual states' adoptions vary its provisions. The Model Regulation specifies in more detail the obligations imposed on insurers. Many state insurance departments have adopted these or other administrative rules as well. Some states have adopted statutes other than the UCSPA that define claims practices standards. For example, some statutes establish a broad duty to observe fair claim practices.⁴⁹

Courts in most jurisdictions also recognize that an obligation of good faith and fair dealing is embodied in every insurance policy as if it were written into the wording of the policy.⁵⁰ The good faith obligation has been a major source of the law of claim

⁴⁹ E.g., Colo. Rev. Stat. Ann. § 10-3-1115 ("A person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed"); La. Rev. Stat. Ann. § 22:1973 (2012) ("The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach."); Md. Code Ann., Ins. § 27-1001 (2012) ("'Good faith' means an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim."); Mo. Ann. Stat. § 375.296 (sanctioning refusal to pay that is "vexatious and without reasonable cause"); Wash. Rev. Code. § 48.30.010(7) (2012) ("An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant.").

⁵⁰ E.g., *Bowler v. Fid. & Cas. Co. of N.Y.*, 250 A.2d 580, 587-88 (N.J. 1969): "Insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer In all insurance contracts, particularly where the language expressing the extent of the coverage may be deceptive to the ordinary layman, there is an implied covenant of good

practices, requiring the insurer to go beyond the letter of the insurance policy and to act fairly and reasonably in processing, investigating, evaluating, and paying a claim.⁵¹

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

Often the most difficult issue in homeowners insurance claims is determining the value of the loss. This should not be an adversarial process; insurance companies are obligated to act reasonably and in the interest of their policyholders to determine the fair value of claims. This requirement is an application of the general principle that companies are required to act in good faith toward their policyholders. In particular, companies should be obligated to observe reasonable standards for determining and paying the actual cash value or the replacement cost of the claim, as applicable under the policy. In cases of total loss, actual cash value means the value of the property as determined by the application of all relevant factors; replacement cost means the cost to repair or replace the property. In cases of partial loss under a replacement cost policy, homeowners expect that their policies enable them to repair or replace the damaged property without additional cost, observing a “functional conception” of indemnity, rather than an “economic conception.”⁵² Under a replacement cost policy, repair or replacement often requires matching the damaged part of the property to the undamaged part to restore the property to the condition prior to loss; for example, replacing only damaged shingles on a roof fails to restore the uniform appearance.

Recommended action:

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

Recommended statutory language:

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

faith and fair dealing that the insurer will not do anything to injure the right of its policyholder to receive the benefits of his contract.”

⁵¹ See Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 *Tort Trial & Ins. Prac. L. J.* 693 (2012).

⁵² See Kenneth S. Abraham & Daniel Schwarcz, *Insurance Law and Regulation* 263 (6th ed. 2015).

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

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

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

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

(b) For a loss that requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment or any other cost except for the applicable deductible.

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

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

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

Current law:

Actual cash value is generally determined according to a “broad evidence” rule, under which any relevant factor is considered in determining the value of a loss.⁵³ Sometimes this translates to replacement cost less depreciation.⁵⁴ The deduction for depreciation only applies to components “that are normally subject to repair and replacement during the useful life of that structure.”⁵⁵ Even then, a number of states have recognized that in cases of partial loss policyholders seek functional indemnity—for example, having a roof repaired without additional expense to the homeowner.⁵⁶

Replacement cost provides the cost to repair or replace without deduction for depreciation. Policies typically provide for payment of actual cash value until the policyholder completes replacement. The procedural requirement in the recommended statutory language is based on the Colorado statute.⁵⁷

Matching to restore a uniform appearance is required by the National Association of Insurance Commissioners’ Unfair Property/Casualty Claims Settlement Practices Model Regulation (MDL-902, 1997). Many states have adopted statutes or administrative rules based on the Model Regulation.⁵⁸ Other states have adopted the matching principle by court decision,⁵⁹ although not all states agree.⁶⁰

⁵³ The leading case is *McAnarney v. Newark Fire Ins. Co.*, 159 N.E. 902 (N.Y. 1928). See Robert H. Jerry, II & Douglas R. Richmond, *Understanding Insurance Law* 638 (5th ed. 2012).

⁵⁴ Cal. Ins. Code § 2051.

⁵⁵ *Id.*

⁵⁶ *Sperling v Liberty Mut. Ins. Co.*, 281 So.2d 297 (Fla. 1973); *Thomas v. American Family Mut. Ins. Co.*, 666 P.2d 676 (Kan. 1983).

⁵⁷ Colo. Rev. Stat. §10–4–110.8 (11).

⁵⁸ Cal. Code of Regs., tit. 10, § 2695.9; Conn. Gen. Stat. § 38a-316e (2014); Fla. Stat. Ann. § 626.9744; Iowa Admin. Code § 191-15.44 (507B); Ky. Admin. Regs. tit. 806, ch. 12 § 095; Neb. Admin. R. & Regs. tit. 210, Ch. 60, § 010; Ohio Admin. Code § 3901-1-54; R.I. Admin. Code § 11-5-73.9; Utah Admin. Code R590.190-13(1)(b).

⁵⁹ E.g., *Nat’l Presbyterian Church, Inc. v. GuideOne Mut. Ins. Co.*, 82 F. Supp. 3d 55, 56-57 (D.D.C. 2015); *Cedar Bluff Townhome Condo. Ass’n, Inc. v. Am. Family Mut. Ins. Co.*, No. A13-0124, 2013 WL 6223454, at *1 (Minn. Ct. App. Dec. 2, 2013), *aff’d*, 857 N.W.2d 290 (Minn. 2014); *Trout Brook S. Condo. Ass’n v. Harleysville Worcester Ins. Co.*, 995 F. Supp. 2d 1035, 1042 (D. Minn. 2014); *Alessi v. Mid-Century Ins. Co., Inc.*, 464 S.W.3d 529, 530 (Mo. Ct. App. 2015).

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

When a loss occurs, homeowners need to receive the benefits of their insurance policies quickly and fully in order to repair their property and rebuilding their lives. Therefore, when disputes concerning claims arise between policyholders and their insurance companies, policyholders need efficient, effective, and expeditious means of resolving the disputes. Litigation ultimately may be necessary but it is a last resort for policyholders because it takes time, delaying the process of recovery, and it is financially and emotionally draining. Two alternatives to litigation that can be effective for homeowners are mediation and appraisal. Mediation provides an informal but structured forum in which policyholders and insurers can meet with the aid of a qualified mediator to discuss and attempt to resolve disputes. Appraisal provides a process by which neutral parties can assess loss and determine the costs of repair. Each needs to be well-designed and supported to meet policyholders' needs.

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

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

Despite the presence of alternatives to litigation such as mediation and appraisal, litigation may be the only means to resolve a dispute or for policyholders to obtain the

⁶⁰ E.g., *Grafteo v. State Farm Fire & Cas., Inc.*, 628 So. 2d 790 (Ala. Civ. App. 1993); *Woods Apartments, LLC v. U.S. Fire Ins. Co.*, No. 3:11-CV-00041-H, 2013 WL 3929706, at *1 (W.D. Ky. July 29, 2013); *Enwereji v. State Farm Fire & Cas. Co.*, No. 10-CV-4967, 2011 WL 3240866, at *1 (E.D. Pa. July 28, 2011).

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

Recommended action:

States should adopt a mediation program for property insurance disputes.

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

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

Recommended statutory language:

[Appraisal: In addition to specifying procedures for appraisal such as are included in the New York Standard Fire Insurance Policy,⁶¹ which has been used as a model in other states, the statute should contain the following language defining the scope of appraisal.]

An appraisal shall determine the actual cash value, the replacement cost, the extent of the loss or damage, and the amount of the loss or damage, which shall be determined as specified in the policy.

[Arbitration:]

No insurance policy shall contain any condition, stipulation or agreement depriving the courts of this state of the jurisdiction of an action against the insurer by providing for arbitration or otherwise. Any such condition, stipulation, or agreement shall be void and shall not preclude any party or beneficiary under the insurance policy from instituting suit or legal action on the contract at any time, and the compliance with the clause or provision shall not be a condition precedent to the right to bring or recover in the action.

⁶¹ N.Y. Ins. Law § 3404.

[States that have adopted a version of the Uniform Arbitration Act or similar legislation also should include a provision like the following in that statute:]

This part shall not apply to any contract of insurance; provided, however, that nothing in this paragraph shall impair or prohibit the enforcement of or invalidate an arbitration clause or provision in a contract between insurance companies.

Current law:

Some states provide for mediation of insurance disputes, either in general or for claims arising after natural disasters.⁶²

Homeowner' policies typically provide for appraisal and some states require that it be available. Courts divide on the issues appropriate for appraisal – whether, for example, appraisal is limited to determining the amount of damage and cost of repair or whether appraisal also may determine the scope of loss and issues of causation.⁶³ Appraisal is more effective if it includes both types of issues, as reflected in the recommended statutory language.⁶⁴ Appraisal does not address issues of interpretation of insurance policy language that determines coverage, which properly are for the courts.

More than a dozen states prohibit enforcement of arbitration clauses in insurance policies by statute or regulation⁶⁵ and another ten states restrict the use of arbitration.⁶⁶ The Federal Arbitration Act as interpreted by the U.S. Supreme Court generally preempts state law that bars or limits arbitration, but state statutes should be upheld based on the reverse preemption provision of the McCarran-Ferguson Act under which states are permitted to regulate the business of insurance.⁶⁷

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

⁶² E.g., Fla. Stat. Ann. § 627.7015.

⁶³ See Couch on Insurance §§ 209.8-9, 210.42 (3rd ed.).

⁶⁴ Based on McKinney's Consol. Laws of N.Y. § 3408(c).

⁶⁵ E.g., Ark. Code Ann. § 16-108-201; Haw. Rev. Stat. § 431:10-221; Kan. Stat. Ann. § 5-401.

⁶⁶ E.g., Utah Admin. Code R590-122; Wyo. Rules Ins. Gen. ch. 23, sec. 9.

⁶⁷ E.g., Standard Sec. Life Ins. Co. v. West, 127 F. Supp.2d 1064 (W.D. Mo. 2001); Friday v. Trinity Universal of Kansas, 939 P.2d 869 (1997).

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

Recommended action:

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

Recommended statutory language:

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

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

- (1) Failing to promptly settle or pay claims where liability has become reasonably clear under one portion of the insurance policy.
- (2) Failing to promptly pay undisputed amounts of partial or full benefits owed after an insurer determines the amounts of partial or full benefits and agrees to coverage of the undisputed amounts.
- (3) Making known to insureds a policy of appealing from mediation, appraisal, or arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises less than the amount awarded in mediation, appraisal, or arbitration.⁶⁸

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

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

⁶⁸ This language would amend Section 4 of the UCSPA. Variations in state adoptions would require appropriate changes.

Current law:

Many states have adopted one or more of these provisions, either by statute or regulation, to provide further definition to the UCSPA's general prohibition on insurance companies' actions in "Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies" and "Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear."⁶⁹ Most states also specify time limits for responding to and paying claims. As to section (1), some states use the recommended language;⁷⁰ others state the duty in the affirmative and refer to an undisputed claim.⁷¹ As to section (2), language differs⁷² and the requirement sometimes has been imposed by court decision.⁷³ As to section (3), the suggested language is commonly used.⁷⁴

Policyholders must have effective remedies if insurance companies act unreasonably.

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

⁶⁹ UCSPA §§ 4.C.-D.

⁷⁰ E.g., Vernon's Ann. Mo. Stat. § 375.1007(15); S.D. Codified L. § 58-33-67(4); Utah Admin. Code R590-190.

⁷¹ "In any case involving a claim in which there is a dispute over any portion of the insurance policy coverage, payment for the portion or portions not in dispute must be made notwithstanding the existence of the dispute where payment can be made without prejudice to any interested party." Nev. Admin. Code § 686A.675; W. Va. Code R. 114-14-6.

⁷² E.g., Fla. Stat. Ann. § 626.9541(1)(i)(4); 806 Ky. Admin. Regs. 12:095 § 6(6); Nev. Admin. Code § 686A.675(7); N.H. Code Admin. R. Ann. Ins 1002.07.

⁷³ E.g., *Chester v. State Farm Ins. Co.*, 117 Idaho 538, 541, 789 P.2d 534, 538 (Idaho Ct. App. 1990); *Castellano v. State Farm Mut. Ins. Co.*, 2013 WL 5519596 (Ill. App. 2103); *Dupree v. Lafayette Ins. Co.*, 51 So. 3d 673 (La. 2010).

⁷⁴ See, e.g., Ind. Code § 27-4-1-4.5(11); Mich. Comp. Laws Ann. § 500.2026(1)(k); N.H. Rev. Stat. § 417:4(XV)(6); N.J. Stat. Ann. § 17B:30-13.1.

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

Recommended action:

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

Recommended statutory language:

- (1) An insured may bring a civil action against an insurer when such person is damaged:
 - (a) when its claim for payment of benefits has been unreasonably delayed or denied, or
 - (b) by a violation of the [state's Unfair Claims Settlement Practices Act or rules adopted by the Insurance Commissioner to implement that statute], notwithstanding that the insurer did not violate any applicable provision with enough frequency as to indicate a general business practice.

[Alternative 2-A:]

- (2) In any action under this statute, the insured shall recover from the insurer
 - (a) actual damages caused by the insurer's misconduct;
 - (b) reasonable attorneys' fees, filing fees, and reasonable costs of suit;
 - (c) interest on the amount of the claim from the date the claim was made by the insured; and

(d) threefold the damages sustained.

[Alternative 2-B:]

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

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

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

and

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

Current law:

Most states provide a remedy for violation of claim practices standards, sometimes referred to as "bad faith." In a majority of those states, insurance companies are liable if they act unreasonably and if they know they have done so or acted in "reckless disregard" of the lack of a reasonable basis for their action.⁷⁵ Other states only require unreasonable behavior for the cause of action.⁷⁶

In cases of late payment or nonpayment, statutes in some states provide remedies beyond payment of the amount already owed under the policy. These remedies include interest at a rate higher than the statutory rate,⁷⁷ other penalties greater than the value of the claim,⁷⁸ and attorney's fees.⁷⁹

In the absence of statutes, courts in bad faith cases often follow ordinary tort damage rules to permit the recovery of all economic losses that flow from the insurance company's breach. These damages may include the cost of obtaining the amount

⁷⁵ The leading case is *Anderson v. Continental Insurance Co.*, 271 N.W.2d 368 (Wis. 1978).

⁷⁶ The leading case is *Gruenberg v. Aetna Insurance Co.*, 510 P.2d 1032 (Cal. 1973).

⁷⁷ E.g., Me. Rev. Stat. Ann. Ins. 24-A, § 2436 (1-1/2% per month); Md. Code Ann., Cts. & Jud. Proc. § 3-1701 (10% per annum); 36 Okla. Stat. Ann. § 3629 (15% per year); 42 Pa. Cons. Stat. Ann. § 8371 (prime rate plus 3%).

⁷⁸ E.g., Ga. Code Ann. § 33-4-6 (2012) (additional damages up to 50% of the loss or \$5,000, whichever is greater, plus attorney's fees); La. Stat. Ann.-R.S. § 22:1821 (2012) (double payment plus attorney's fees in health and accident insurance); La. Stat. Ann.-R.S. § 22:1892(B)(1) (2012) (penalty of greater of 50% of amount owed or \$1,000 in other insurance); Rev. Code Wash § 48.30.015(2) (2012) (up to three times actual damages, plus attorney's fees). Other statutes authorize punitive damages (42 Pa. Cons. Stat. Ann. § 8371) or exemplary damages (Mont. Code Ann. § 33-18-242) as determined by the trier of fact.

⁷⁹ E.g., Ark. Code Ann. § 23-79-208; Colo. Rev. Stat. Ann. § 10-3-1115 (2012); Fla. Sta. Ann. § 627.428; Md. Code Ann., Cts. & Jud. Proc. § 3-1701 (2012); New Mex. Stat. Ann. § 39-2-1; 42 Pa. Cons. Stat. Ann. § 8371 (2012).

properly due under the policy, including attorney's fees and litigation costs,⁸⁰ and emotional distress in appropriate cases.⁸¹ In appropriate cases, punitive damages may be awarded as well.⁸²

United Policyholders has published a fifty-state survey of this body of law, available at the UP website, which should be consulted for more detail.⁸³

⁸⁰ *E.g.*, *Brandt v. Superior Court (Standard Ins. Co.)*, 693 P.2d 796, 798-99 (Cal. 1985); *White v. W. Title Ins. Co.*, 710 P.2d 309, 320 (Cal. 1985).

⁸¹ *E.g.*, *Gourley v. State Farm Mut. Auto. Ins. Co.*, 822 P.2d 374, 378 (Cal. 1991); *Farr v. Transamerica Occidental Life Ins. Co.*, 699 P.2d 376, 382 (Ariz. Ct. App. 1984).

⁸² *E.g.*, *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368, 379 (Wis. 1978); *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334, 347-48 (Haw. 1996).

⁸³ See also Jay M. Feinman, *The Law of Insurance Claim Practices; Beyond Bad Faith*, 47 *Tort Trial & Ins. Prac. L.J.* 693 (2012).

Essential Protections for Disaster Victims

Policyholders who suffer losses due to natural disasters such as hurricanes, wildfires, or tornadoes face all of the potential problems that other policyholders confront and more. When policyholders need their insurance most, and when many policyholders in an area need their insurance all at once, events coincide to make it harder for insurance to work promptly and fairly. The Essential Protections address the special needs of disaster victims.

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Many of the Essential Protections that apply in other circumstances are extremely important for disaster victims as well. Clear explanations of key policy terms and information about the need for and availability of additional insurance for natural disasters makes it more likely that consumers will purchase insurance that will protect them if disaster strikes. Minimum protections in policies and the offer of more coverage for additional living expense, law and ordinance upgrades, and extended replacement cost make policies better suited to the special needs for rebuilding after a disaster. A fair claims process with reasonable time limits, standards for valuing losses, alternative dispute resolution systems such as mediation, and the right to sue for unreasonable conduct protects disaster victims if problems arise.

Often, however, disaster victims need more extensive protections because of the distinctive conditions created following disasters. After a disaster insurance companies can lack the capacity to promptly process claims, the availability of contractors to repair or rebuild declines and the price of labor and materials rises, and public services are overwhelmed. The Essential Protections for disaster victims mandate flexibility in the claim process, standards that prevent unexpected gaps in insurance due to unfair exclusions, and prevention of dislocation in the insurance market.

The Essential Protections apply to homeowners' insurance and other forms of private insurance on residential property. Nearly all of those policies exclude coverage for damage caused by flooding, variously defined in the policies, which has led to the

creation of the federal government's National Flood Insurance Program. Because that program is largely governed by federal and not state law it is not within the scope of the Essential Protections. One issue that often arises is damage caused by an excluded flood loss and an included cause such as wind. The Essential Protection provision on causation does address that issue.

Disaster victims should have flexibility in coverage provisions and the claims process.

- **Policyholders after disasters should have a reasonable time for additional living expense and for filing claims.**

After a disaster policyholders often are unable to meet the ordinary conditions and time limits specified in insurance policies through no fault of their own. Entire communities may be inaccessible for periods of time, preventing policyholders from returning to their homes. Insurance companies are inundated with inquiries and claims, delaying communication with policyholders. Contractors are overwhelmed with work, delaying repairs and rebuilding. In those circumstances, policyholders should be granted additional time for processing their claims. Some types of problems can be anticipated and specified in advance, such as the need to extend time limits for filing additional living expense and full replacement cost claims. Other types of problems depend on the situation and require action by insurance departments to make sure that insurance companies recognize the need to be flexible.

Recommended action:

States should adopt statutes that extend the time for additional living expense and for filing claims after a disaster and that authorize insurance departments to extend other time limits. Insurance departments should exercise the authority granted to make sure that policyholders have adequate time to pursue claims after disasters.

Recommended statutory language:

Following a catastrophic event for which a state of emergency has been declared by the President of the United States or the Governor or for which a local emergency has been declared by the executive officer or governing body of local

government or which has been declared by a nationally recognized catastrophe loss index provider:

- (a) Coverage for additional living expense in a homeowners insurance policy that provides for such coverage shall be available for a period of not less than twenty-four months.
- (b) In a homeowners' insurance policy providing for replacement cost, no time limit of less than twenty-four months from the date that the first payment toward the actual cash value is made shall be placed upon the insured in order to collect the full replacement cost of the loss, subject to the policy limit.
- (c) The insurance department shall have the authority to extend time for policyholders to give notice of loss to an insurance company, file proof of loss, or satisfy other time limits imposed by the terms and conditions of a homeowners insurance policy. Any extension of time required by department action under this paragraph beyond the period provided in the policy shall not act to increase the coverage available or policy limit in force at the time of the loss.

Current law:

The California Insurance Code permits extension of time or coverage following disasters.⁸⁴ Other states took similar action in response to particular events such as Hurricane Katrina, Superstorm Sandy, and the Louisiana flooding of 2016. Responses to particular disasters are helpful, but the enactment of statutes to deal with all disasters provides certainty for policyholders and insurance companies and avoids the need for hasty action.

Disaster victims should have clear rules about causes of loss to avoid unfair gaps in coverage.

- **Policyholders should be compensated for losses due to covered causes.**

Homeowners insurance policies cover losses caused by some risks and exclude coverage caused by other risks. For example, policies typically cover hurricane damage caused by high winds but exclude losses caused by flooding during a hurricane. In

⁸⁴ E.g., Cal. Ins. Code § 2051.5.

many cases, however, a loss will occur due to a covered cause and an excluded cause, acting either in sequence, together, or in a manner that cannot be determined after the fact. This is often a problem in catastrophic weather events, in which damage occurs by wind and water. Many homeowners policies have language that attempts to deny coverage in these cases, even if it is clear that part of the damage was due to a covered cause of loss. One widely used policy bars coverage due to an excluded cause “regardless of any other cause or event contributing concurrently or in any sequence to the loss” —even if the “other cause” is covered under the policy. Terms such as this—known as “anti-concurrent causation clauses”—disappoint the reasonable expectations of policyholders that they will be compensated for losses due to covered causes and can be particularly problematic after catastrophic events.

Recommended action:

States should ensure that losses due to covered causes are covered by limiting the scope of anti-concurrent causation clauses.

Recommended statutory language:

An insurer shall not deny or exclude coverage for any claim for loss or damage that would otherwise be covered by a policy solely because an event or peril not covered or specifically excluded under the policy was a contributing factor in such loss or damage or occurred simultaneously with the event or peril that was covered.

Current law:

The majority of states observe the rule of “efficient proximate cause” in cases involving covered and excluded causes of loss.⁸⁵ Efficient proximate cause is often described as “the predominating cause of the loss” that “looks to the quality of the links in the chain of causation.”⁸⁶

Although a few statutes define causation under insurance policies,⁸⁷ it has been left to the courts (sometimes applying the relevant statutes) to decide whether an anti-

⁸⁵ 5-44 Appleman on Insurance § 44.03.

⁸⁶ Murray v. State Farm Fire & Cas. Ins. Co., 509 S.E.2d 1, 12 (W. Va. 1998).

⁸⁷ Cal Ins Code § 530; Fla. Stat. § 627.702(1)(b); N.D. Cent. Code § 26.1-32-01.

concurrent causation clause in an insurance policy can narrow the rule of causation that otherwise would be dictated by state law. The states are divided on this issue.⁸⁸

Disaster victims should be protected against sudden dislocations in the insurance market.

- **Insurance companies may not decline, cancel, nonrenew, surcharge, or increase premiums because of disasters.**

Following a wildfire, hurricane, or other disaster that causes a large number of losses to a community or region, insurance companies sometimes react by cancelling, failing to renew or imposing a surcharge on existing policies, and declining to offer new policies in the affected areas. Over time the companies may moderate their positions as the extent of losses and likely future risks become clearer, but in the meantime insurance may be unavailable or unaffordable.

An Essential Protection is to ensure that catastrophes or other significant events do not cause a sudden and often unjustified dislocation in the insurance market.

Recommended action:

States should limit the ability of insurance companies to cause temporary dislocations in the market by failing to write or renew policies or imposing higher costs after a major disaster.

Recommended statutory language:

(1) The declination, cancellation, or nonrenewal of a homeowners insurance policy or the addition of a surcharge or an increase in the premium of such policy is prohibited if the declination, cancellation, nonrenewal, addition of a surcharge, or increase in premium is based solely on any loss incurred as a result of one or more catastrophic events for which a state of emergency has been declared by the President of the United States or the Governor or for

⁸⁸ Leading cases include *Safeco Ins. Co. of America v. Hirschmann*, 773 P.2d 413 (Wash. 1989), (clause unenforceable); *State Farm Fire & Cas. Ins. Co. v. Bongen*, 925 P.2d 1042 (Alaska 1996) (clause enforceable). See Annot., *Validity, Construction, and Application of Anticoncurrent Causation (ACC) Clauses in Insurance Policies*, 37 A.L.R.6th 657.

which a local emergency has been declared by the executive officer or governing body of local government or which has been declared by a nationally recognized catastrophe loss index provider.

(2) In the case of a total loss to the primary insured structure under a homeowners' insurance policy caused by a disaster as defined in section (1), the insurer shall offer to, at least once, renew the policy, except for the following reasons:

- (a) Nonpayment of premium
- (b) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured
- (c) Discovery of fraud or material misrepresentation by the named insured or his representative in obtaining the insurance or pursuing a claim under the policy
- (d) Discovery of grossly negligent acts or omissions by the insured or his or her representative substantially increasing any of the hazards insured against.

Current law:

Many states have statutes that prohibit adverse actions after disasters or due to weather-related losses. A large number of states prohibit cancellation or nonrenewal due to weather-related events other than catastrophes, such as prohibiting cancellation or nonrenewal "solely as a result of claims arising from natural causes"⁸⁹ or because of a claim "resulting from an act of God".⁹⁰ By their terms, these statutes would include adverse action due to catastrophes. Statutes in other states refer specifically to disasters.⁹¹ Some statutes are more limited, for example, permitting nonrenewal where "the claim or loss identifies or confirms an increase in hazard, a material change in the risk assumed or a breach of contractual duties, conditions or warranties that materially affect the nature or the insurability of the risk"⁹² or where the insured has failed to take action reasonably requested by the insurer "to prevent recurrence of damage to the

⁸⁹ Ark. Code Ann. § 23-63-109.

⁹⁰ S.C. Code 1976 § 38-75-790. Even broader are statutes such as 36 Ok. Stat. Ann. § 3639.1, prohibiting cancellation solely because of a first claim except for specified circumstances such as a substantial increase in risk.

⁹¹ E.g., Ct. Gen. Stat. Ann. § 38a-316d; N. M. Stat. Ann. § 59A-16-20.1.

⁹² N.J. Stat. Ann. 17:36-5.20a; see also N.J. Admin. Code § 11:1-22.2.

insured property”⁹³ or “to prevent a future similar occurrence of damage to the insured property.”⁹⁴ Several states limit adverse action due to weather-related claims in specified time periods, often subject to other requirements.⁹⁵ A few states authorize the insurance department to declare a cooling-off period following a disaster during which cancellations and nonrenewal are suspended⁹⁶ or to take other action.⁹⁷

⁹³ Fla. Stat. Ann. § 627.4133.

⁹⁴ Fla. Stat. Ann. § 627.4133(6).

⁹⁵ E.g., Utah Code. Ann. 1953 § 31A-21-303; N. D. Stat. § 26.1-25.2-03; La. Rev. Stat. § 22:1265; § 22:1333.

⁹⁶ E.g., R.I. Admin. Code 11-5-110:12; N.Y. Ins. Law § 3425; Fla. Stat. Ann. § 627.4133.

⁹⁷ E.g., Ala. Dep’t of Ins. Bulletin 2010-10, citing the Unfair Trade Practices Law, Ala. Code § 27-12-1 et seq.; RI Ins. Reg. 110.



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