UNFAIR CLAIMS SETTLEMENT PRACTICES (REGULATIONS) AND PRIVACY OF CONSUMER FINANCIAL INFORMATION (REGULATIONS) – THEIR POTENTIAL IMPACT UPON BAD FAITH ACTIONS

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TABLE OF CONTENTS

Pages

UNFAIR CLAIMS SETTLEMENT PRACTICES (REGULATIONS)

INTRODUCTION

This portion of the paper is intended to provide you with a "handy" list of the requirements and time limits under the Unfair Claims Settlement Practices Regulations. 31 Pa. Code §§ 146.1-146.9 The definitions, requirements and time limits are taken directly from the regulations. If you have any questions, please feel free to contact me.

SECTION 146.1 SCOPE OF THE ACT

The regulations were adopted to try to provide the industry with certain minimum standards which, if violated with a frequency that would constitute a general business practice, would be deemed to constitute unfair claims settlement practice. One violation of these regulations would not constitute an unfair claims settlement practice. However, the greater the number of violations the closer a company would be to establishing a general unfair claims settlement practice.

SECTION 146.2 DEFINITIONS

The following are some of the definitions which are included in the regulations. These definitions are important in determining the requirements and time limits applicable to the various sections. All the definitions have not been included because they would not be relevant for these purposes.

Agent - An individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

Claim - A demand for payment by a claimant and not an inquiry concerning coverage.

Claimant - Either a first-party claimant, a third-party claimant or both, and including the claimant's attorney and a member of the claimant's immediate family designated by the claimant.

First-party claimant - An individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or contract arising out of the occurrence of the contingency or loss covered by such policy or contract.

Insured - A natural person, association, corporation, partnership or other legal entity who is insured under an insurance policy or contract issued in this Commonwealth.

Notification of Claim - A notification, whether in writing or other means acceptable under the terms of an insurance policy or contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim.

Third-party claimant - An individual, corporation, association, partnership or other legal entity asserting a claim against an individual, corporation, association, partnership or other legal entity insured under an insurance policy or contract of an insurer.

SECTION 146.3 FILE AND RECORD DOCUMENTATION

The claim file must contain notes and work papers pertaining to the claim in such detail that all pertinent events and dates of events can be reconstructed.

SECTION 146.4 MISREPRESENTATION OF POLICY PROVISION

(a)-(b) An insurer must fully disclose to first-party claimants pertinent benefits, coverages or other provisions under which a claim is presented or which are pertinent to a claim.

(d) An insurer may not, except where there is a time limit specified in the policy, seek to relieve the company of its obligations if a time limit is not complied with, unless the failure to comply with the time limit prejudices the right of the insurer

SECTION 146.5 FAILURE TO ACKNOWLEDGE PERTINENT COMMUNICATIONS - TIME LIMITS

(a) Ten Working Days - Notification of Claim

Upon receiving notification of a claim every insurer shall, within **ten working days**, acknowledge the receipt of the notice unless payment is made within that period of time.

(b) Fifteen Working Days - Insurance Department Inquiry

Every insurer shall, within **fifteen working days** of an inquiry from the department, furnish an adequate response.

(c) Ten Working Days - Reply Period

An appropriate reply shall be made within **ten working days** on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Ten Working Days - Reply Period For First-Party Claims

Every insurer, upon receiving notification of a claim, shall provide within **ten working days**, necessary claim forms, instructions and reasonable assistance so that "first-party claimants" can comply with policy conditions and reasonable requirements of the insurer. By complying with this subsection, the insurer shall be deemed to comply with subsection (a).

SECTION 146.6 STANDARDS FOR PROMPT INVESTIGATION OF CLAIMS - TIME LIMITS

Within **thirty days** after notification of a claim, every insurer shall complete its investigation. If the investigation cannot be completed within **thirty days** then every **forty-five days** thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

SECTION 146.7 STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS APPLICABLE TO INSURERS

(a) Acceptance or Denial of Claim

(1) Fifteen Working Days

Acceptance or denial of a first-party claim shall be made within **fifteen working days** after receipt by the insurer of properly executed proofs of loss. The claimant shall be advised, in writing, of the acceptance or denial of the claim by the insurer. In order for a denial to be effective, it must refer to the provision, condition or exclusion which forms the basis of the denial.

(2) Fraud Exception - Reasonable Time

Where there is a reasonable basis supported by specific information that the "first-party claimant" has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer shall advise the claimant of acceptance or denial of the claim within a **reasonable time** for a full investigation after receipt by the insurer of a properly executed proof of loss.

(c) The Forty-Five Day Cycle - First-Party Claims

(1) General Rule

Where an insurer needs more time to determine whether a "first-party claim" should be accepted or denied, it shall notify the "first-party claimant" within **fifteen working days** after receipt of the proofs of loss, giving the reason or reasons that more time is needed. If the investigation remains incomplete, the insurer shall, thirty days from the date of the initial notification and every forty-five days thereafter, send to the claimant a letter setting forth the reason or reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Fraud Exception

The fraud exception would also apply to this **forty-five day cycle** and extend the time limit to a **reasonable time**.

(e) Unrepresented Claimants - Statute of Limitations

Insurers may not continue negotiations for settlement of a claim directly with a claimant, who is neither an attorney nor represented by an attorney until the rights of the claimant may be affected by a statute of limitation or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the rights of the claimant. The notice shall be given to "first-party claimants" **thirty days**, and to "third-party claimants" **sixty days**, before the date on which the time limit may expire.

SECTION 146.8 STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS APPLICABLE TO AUTOMOBILE INSURANCE

(a) Insurers may not recommend that third-party claimants make a claim under their own policies solely to avoid paying claims under its policy.

(b) Insurers may not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at specific repair shops.

(c) Insurer shall, upon request of the claimant, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis and a deduction for expenses cannot be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction may then be for only a pro-rata share of the allocated loss adjustment expense.

SECTION 146.9 COMPARATIVE NEGLIGENCE

(a) Insurers must fully disclose to claimants the basis in fact or in applicable law for the offer or denial where comparative negligence is applied to a claim settlement offer or denial.

(b) Comparative negligence should not be applied to a claim settlement to reduce amounts claimants would otherwise be entitled to but for their negligence without reasonable evidence of the negligence and its relevance to the total negligence involved.

QUICK REFERENCE TO TIME LIMITS UNDER THE UNFAIR CLAIMS SETTLEMENT PRACTICES (REGULATIONS)

		RESPONSE TIME
1.	Notice of Claims	10 days *
2.	Inquiries from Insurance Department	15 days *
3.	Inquiries from Claimant	10 days *
4.	Complete Investigation	30 days
5.	Fraudulent Claims if Based on Specific Information	"Reasonable time to investigate"
6.	Update Status and Explain Delay	45 days
7.	Accept or Deny Claim After Receipt of Proof of Loss	15 days *
8.	First-Party Claims Where More Time Needed	Notify claimant in 15 days* of proofs that you will need more time with 30 to 45 day updates
9.	Notification of Statute of Limitations Approaching During Negotiations	30 Days Prior Notice to First-Party Claimants 60 Days Prior Notice to Third-Party Claimants

* Working Days

APPENDIX "A"

PRIVACY OF CONSUMER FINANCIAL INFORMATION (REGULATIONS) – THEIR POTENTIAL IMPACT IN BAD FAITH ACTIONS

The Pennsylvania Insurance Department drafted regulations to enforce the Federal Privacy Act's requirements. The Federal Privacy Act is known as Title V of the Gramm-Leach-Bliley Act, or the Financial Services Modernization Act. The Pennsylvania Regulations are titled the "Privacy of Consumer Financial Information, " 31 Pa. Code. §146a.1, *et seq.* and were issued under the Administrative Code and the Unfair Insurance Practices Act. The following is a brief discussion regarding each of the provisions.

SUBCHAPTER A. - GENERAL PROVISIONS

The purpose of the regulations is to set forth the requirements for licensees (insurers, producers or others required to be licensed pursuant to The Insurance Company Law) for handling nonpublic personal financial information about individuals. §146a.1. At the inception of an insurer or broker's relationship with a consumer, an insurer or broker must give an initial notice to an insurer that the broker or insurer will not disclose nonpublic personal financial information concerning the buyer to third parties except as permitted by law. 146a.2

"Nonpublic personal financial information" includes information that a consumer provides to a licensee to obtain insurance and any information the consumer gives to the licensee resulting from the transaction, and any information the licensee otherwise obtains as a result of the transaction. Simple examples include information on an account, account balance and payment history, information that the consumer is a licensee's customer, any information regarding loans, information the licensee collects from an Internet web-server or information from a consumer report. Id. In contrast, **non-public information** includes Federal, State or local government records, widely distributed media or disclosures to the public required by Federal, State or local law.

SUBCHAPTER B. - PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

A licensee must provide an initial notice to customers and consumers regarding its privacy policies and procedures. §146a.11. An annual notice regarding a licensee's privacy policies and practices must be provided to current customers on an annual basis thereafter. §146a.12. The notice must contain certain information regarding the disclosure of nonpublic personal financial information and affiliated and nonaffiliated third parties to whom nonpublic personal financial information can be disclosed. §146a.13. In certain circumstances, a licensee is required to send an "opt out notice" to consumers, informing them that they have the right not to be subject to the privacy requirements of the licensee. §146a.14. Licensees may provide revised notices to its consumers, if applicable. §146a.15. The regulations also set forth the means of delivery of the privacy notices. §146a.16.

SUBCHAPTER C. - LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

A licensee may not disclose non-public personal financial information about a consumer to a nonaffiliated third party unless an initial notice was provided, an opt out notice was required, the licensee has given a consumer a reasonable time to opt out of the disclosure, or the consumer does not opt out of the licensee's privacy policies and procedures. §146a.21. However, there are limits on re-disclosure and reuse of nonpublic personal financial information, §146a.22, and limits on sharing account number information for marketing purposes. §146a.23.

SUBCHAPTER D. – EXCEPTIONS TO LIMITS ON DISCLOSURES OF NONPUBLIC PERSONAL FINANCIAL INFORMATION

There are exceptions to opt out requirements for disclosure of nonpublic personal financial information to: 1) service providers and to nonaffiliated third parties who have joint marketing agreements to promote the licensee's products or services, §146a.31; 2) nonaffiliated

third parties regarding processing and servicing transactions, §146a.32, or 3) to others under miscellaneous exceptions, §146a.33.

SUBCHAPTER E. – ADDITIONAL PROVISIONS

The final section details other miscellaneous provisions. For example, the regulations are not to be construed as modifying, limiting, or superceding the operation of the Fair Credit reporting Act. §146a.41. Further, a licensee may not discriminate against any consumer or customer because he or she opted out from the licensee's policies and procedures regarding disclosure of nonpublic personal financial information. §146a.42. A violation of any of the regulations is deemed to be an unfair method of competition and an unfair or deceptive act or practice and is subject to the penalties or remedies in the Unfair Insurance Practices Act. §146a.43. The effective date of the regulations is July 1, 2001. §146a.44. Finally, the regulations contain an appendix with sample clauses for a privacy notice. See Appendix B.

EXAMPLES OF HOW THE UNFAIR INSURANCE PRACTICES ACT AND UNFAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS HAVE BEEN USED IN BAD FAITH LITIGATION

Many insureds are trying to use the Unfair Insurance Practices Act ("UIPA") and Unfair Claims Settlement Practices Regulations ("UCSP") to support independent claims for bad faith against insurers. Fortunately, the Courts have steadfastly refused to allow the UIPA and UCSP to support independent causes of action for bad faith. The Courts have also limited discovery based upon alleged violations of the UIPA and UCSP.

A. THE USE OF THE UIPA AND UCSP AT TRIAL

Under Pennsylvania law, there is no private cause of action under the UIPA or UCSP. Smith v. Nationwide Mut. Fire Ins. Co., 935 F. Supp. 616 (W.D. Pa. 1996). Although a plaintiff may allege violations of the UIPA and UCSP to support a claim for bad faith, the allegations alone cannot sustain a bad faith claim. Peer v. Minnesota Mut. Fire Ins. Co., 1995 U.S. Dist. LEXIS (E.D. Pa. March 27, 1995). Consequently, mere allegations that an insurer violated UIPA and UCSP do not amount to bad faith. Williams v. Hartford Casualty Ins. Co., 83 F. Supp. 2d 567 (E.D. Pa. 2000).

However, courts will consider alleged violations of the UIPA and UCSP in determining whether the defendant's conducted violated the bad faith statute. Romano v. Nationwide Mut. Fire Ins. Co., 646 A.2d 1228 (Pa. Super. 1994); see also, Cohen v. State Auto Propr. & Cas. Co., 2001 U.S. Dist. LEXIS 1178 (E.D. Pa. February 8, 2001). For example, in Romano, the Court held that because the precise meaning of "bad faith" was unclear, it could look to the UIPA to clarify the meaning of that term. Id.

In Williams, plaintiff alleged that the insurer's violations of the UIPA and UCSP constituted bad faith per se. Plaintiff claimed that Hartford did not timely complete its

investigation of the plaintiff's claim and also failed to send the plaintiff proper letters regarding the status of the violation. Both of these actions allegedly violated the UIPA. The Court held that Hartford's negligence, in failing to advise the plaintiff of the status of its investigation, did not arise to bad faith. Most importantly, the court the reaffirmed that Hartford's alleged violation of the UIPA, by itself, was not evidence of bad faith.

Unlike the plaintiffs in Romano and Williams, the plaintiff in Albert v. Nationwide Mut. Fire Ins. Co., 2001 U.S. Dist. LEXIS (M.D. Pa. May 22, 2001), allege that Nationwide's numerous violations of the UIPA and UCSP were evidence of bad faith. Plaintiff alleged that Nationwide failed to properly advise the plaintiff whether it would accept or deny coverage within the time limits prescribed by the UIPA. The plaintiff also alleged that Nationwide violated the UCSP regulations which require insurance companies to act in good faith to settle claims promptly, fairly and equitably where liability is clear. The court found that while Nationwide might have technically violated the UIPA and UCSP, its violations did not constitute bad faith. The Court examined Nationwide's conduct and found that it was in constant contact with plaintiff's counsel and that there was no evidence that Nationwide was dilatory or caused unreasonable delay in handling the claim. Ultimately, the Court found that Nationwide did not act in bad faith.

B. THE IMPACT OF UIPA AND UCSP ON DISCOVERY

The UIPA and UCSP are also affecting plaintiffs' choice of discovery. In Cantor v. The Equitable Life Assurance Society of the United States, 1998 U.S. Dist. LEXIS 8435 (E.D. Pa. June 9, 1998), plaintiff alleged that Equitable acted in bad faith in handling his disability claim. Plaintiff served interrogatories upon Equitable, requesting information regarding Equitable's procedures for implementing the standards set forth in the UIPA and UCSP. After Equitable

objected to the interrogatories, the plaintiff filed a motion to compel. The court denied the plaintiff's motion to compel finding that plaintiff could obtain the information from a less burdensome source, such as through oral depositions.

Plaintiffs also are attempting to have their experts testify regarding the applicability of the UIPA and UCSP in bad faith litigation. In Dinner v. United Services Automobile Association Casualty Ins. Co., 2002 U.S. App. LEXIS 3408 (3d Cir. February 27, 2002), plaintiff alleged that USAA acted in bad faith in handling an underinsured motorist coverage claim. Plaintiff argued that the trial court erred when it precluded her expert from testifying about the code of conduct for insurers set forth in the UIPA and UCSP. Plaintiff's expert intended to testify that Pennsylvania, through the adoption of the UIPA and UCSP, set forth the statutory obligation for an insurance company to follow in handling claims and that USAA had deviated from that code of conduct by violating several of the provisions.

The Third Circuit upheld the trial court's ruling and barred the plaintiff's expert from using the UIPA or UCSP as underpinnings for her findings. Specifically, the Court held that the regulations limit the scope of potential violations by requiring that the standards be violated with a frequency that indicates a general business practice to constitute unfair claims settlement practices. Consequently, these violations are not equivalent to establishing bad faith. Moreover, the Court upheld the trial court's decision that any limiting instruction about the UIPA and UCSP which would have allowed the expert to testify about them, would be far out weighed by the prejudice that would result from their admission into evidence.

But see Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583 (E.D. Pa. 1999) (holding expert could refer to UIPA and UCSP in expert report, though court would not comment on whether expert could comment on those standards in courtroom testimony).

C. CONCLUSION

Even though the UIPA and UCPS do not create private causes of action in Pennsylvania, courts will still examine a plaintiff's claims of alleged violations of the UIPA and UCPS as evidence of bad faith. Plaintiffs are seeking more discovery based upon these provisions and are attempting to use expert testimony based upon the UIPA and UCPS to support their claims of bad faith.

To date, companies have had success resisting introduction of the UIPA and UCSP into evidence and limiting their use in expert reports. The key to any successful defense is to remind judges of the purpose of the regulations is to regulate frequent violations constituting general business practices and not individual claims. Consequently, these regulations should not be the sole basis for any claim for bad faith.