806 KAR 12:095. Unfair claims settlement practices for property and casualty insurance.

RELATES TO: KRS 304.12-010, 304.12-220, 304.12-230, 304.12-235, 304.14-400, 304.20-070, 304.20-150-304.20-180, 342.325
STATUTORY AUTHORITY: KRS 304.2-110, 304.3-200(1)(e)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110 authorizes the Commissioner of Insurance to make reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. This administrative regulation establishes unfair property and casualty insurance claims settlement practices, effectuating KRS 304.3-200(1)(e), 304.12-010, and 304.12-230.

Section 1. Definitions. (1) "Agent" means any person authorized to represent an insurer with respect to a claim;
(2) "Claimant" means either a first party claimant, a third-party claimant, or both and includes the claimant's designated legal representative, such as an administrator, executor, guardian, or similar person, and includes a member of the insured's immediate family designated by the claimant;
(3) "Claim file" means any retrievable electronic file, paper file, or both;
(4) "Commissioner" is defined in KRS 304.1-050(1);
(5) "Days" means any day, Monday through Friday, except holidays;
(6) "First party claimant" means a person asserting a right to payment under an insurance policy, certificate, or contract arising out of the occurrence of the contingency or loss covered by the policy, certificate, or contract;
(7) "Insurer" is defined by KRS 304.1-040;
(8) "Investigation" means all activities of an insurer related to the determination of liabilities under coverages afforded by a policy, certificate, or contract;
(9) "Local market area" means a reasonable distance surrounding the area where a motor vehicle is principally garaged, or the usual location of the article covered by the policy. This area shall not be limited to the geographic boundaries of the Commonwealth;
(10) "Notification of claim" means any notification, whether in writing or by other means acceptable under the terms of the policy, certificate, or contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;
(11) "Policy", or "certificate", or "contract" means any contract of insurance or indemnity, except for:
(a) Fidelity, suretyship, or boiler and machinery insurance; or
(b) A contract of workers' compensation insurance unless it satisfies the requirements of Section 2 of this administrative regulation.
(12) "Replacement crash part" means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels; and
(13) "Third-party claimant" means any person asserting a claim against any person under a policy, contract, or certificate of an insurer.

Section 2. Scope and Purpose of this Administrative Regulation. (1) This administrative regulation establishes minimum standards for the investigation and disposition of property and casualty insurance claims arising under policies, certificates, and contracts. This administrative regulation shall not cover claims involving fidelity, suretyship, or boiler and machinery insurance. This administrative regulation shall not cover claims involving workers' compensation if those questions arise under KRS Chapter 342 since those questions shall be resolved by workers' compensation administrative law judges or arbitrators, pursuant to KRS 342.325. This administrative regulation shall apply to claims for unearned premium refunds under workers' compensation policies since workers' compensation administrative law judges or arbitrators do not have jurisdiction over those claims. This administrative regulation establishes procedures and practices which constitute unfair claims settlement practices.
(2) Statement of enforcement policy. If complaints are filed with the commissioner, the commissioner shall note violations of this administrative regulation after the insurer or agent has been given an opportunity to pay the claim and any interest thereon.
(3) This administrative regulation establishes standards for the commissioner in investigations, examinations, and administrative adjudication and appeals therefrom. A violation of this administrative regulation shall be found only by the commissioner. This administrative regulation shall not create or imply a private cause of action for violation of this administrative regulation.

Section 3. File and Record Documentation. Each insurer's claim files for policies, certificates, or contracts are subject to examination by the commissioner or the commissioner's designees. To aid in an examination:
(1) The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, and date of denial or date closed without payment. This data shall be available for all open and closed files for the current year and the five (5) preceding years.
(2) The insurer shall maintain documentation in each claim file to permit reconstruction of the insurer's activities relative to each claim.
(3) The insurer shall note each relevant document within the claim file as to date received, date processed, or date mailed.
(4) If an insurer does not maintain hard copy files, claim files shall be accessible from a computer terminal available to examiners or micrographics and be capable of duplication to legible hard copy.

Section 4. Misrepresentation of Policy Provisions. (1) Insurers and agents shall not misrepresent or conceal from first party claimants any pertinent benefits, coverages, or other provisions of any insurance policy or insurance contract if the benefits, coverages, or other provisions are pertinent to a claim, pursuant to KRS 304.12-230(1).
(2) Insurers shall not deny a claim on the basis of failure to exhibit property unless there is documentation in the claim file of breach of the policy provisions.
(3) Insurers shall not deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless written notice of loss is a written condition in the policy, certificate, or contract and the first-party claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the first-party claimant's duty to cooperate with the insurer.
(4) Insurers shall not indicate to a first party claimant on a payment draft, check, or in an accompanying letter that payment is "final" or "a release" of any claim unless:
(a) The policy limit has been paid; or
(b) There has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy, certificate, or contract.
(5) Insurers shall not issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which releases the insurer or its insured from total liability.

Section 5. Failure to Acknowledge Pertinent Communications. (1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of the notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) If an insurer receives an inquiry from the Department of Insurance respecting a claim, the insurer shall, within fifteen (15) days of receipt of the inquiry, furnish the Department of Insurance with an adequate response to the inquiry in duplicate.

(3) The insurer shall make an appropriate reply within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) 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. Compliance with this subsection within fifteen (15) days of notification of a claim shall constitute compliance with subsection (1) of this section.

Section 6. Standards for Prompt, Fair, and Equitable Settlements Applicable to All Insurers. (1)(a) Pursuant to KRS 304.12-230(5), an insurer shall, pursuant to KRS 304.12-235(1), affirm or deny any liability on claims within a reasonable time and shall offer any payment due within thirty (30) calendar days of receipt of due proof of loss. If claims involve multiple coverages, payments which are not in dispute shall be tendered within thirty (30) calendar days of receipt of due proof of loss.

(b) If there is a reasonable basis supported by specific information available for review by the commissioner that a claimant has fraudulently caused or contributed to the loss, the insurer shall:

1. Be relieved from the requirements of this subsection; and

2. Advise the first party claimant of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(2)(a) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within thirty (30) calendar days after receipt of the proofs of loss, giving the reasons more time is needed.

(b) If the investigation remains incomplete, the insurer shall, forty-five (45) calendar days from the date of the initial notification and every forty-five (45) calendar days thereafter, send to the first party claimant a letter stating the reasons additional time is needed for investigation.

(3) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(4) Insurers shall not continue negotiations for settlement of a claim directly with a first party claimant who is not legally represented if the first party claimant's rights may be affected by a statute of limitations or a time limit in a policy, certificate, or contract, unless the insurer has given the first party claimant written notice of the limitation. The notice shall be given to the first party claimant at least thirty (30) calendar days before the date on which the time limit expires.

(5) Insurers shall not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

(6) Subject to subsection (1)(a) of this section relating to first party claims, insurers shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. If claims involve multiple coverages, and if the payee is known, payments which are not in dispute shall be tendered within thirty (30) calendar days.

(7) Insurers shall not request or require any insured to submit to a polygraph examination unless authorized under the applicable policy, certificate, contract, or applicable law.

Section 7. Standards for Prompt, Fair, and Equitable Settlements Applicable to Motor Vehicle Insurance. (1) If the policy, certificate, or contract provides for the adjustment and settlement of first party motor vehicle total losses on the basis of actual cash value or replacement with another of like kind and quality, one (1) of the following methods shall apply:

(a) The insurer may elect to offer a replacement motor vehicle which is a specific comparable motor vehicle available to the insured, with all applicable taxes, license fees (if these fees cannot be refunded by the Transportation Cabinet), and other fees incident to transfer of evidence of ownership of the motor vehicle paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof shall be documented in the claim file;

(b) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable motor vehicle including all applicable taxes, license fees (if these fees cannot be refunded by the Transportation Cabinet), and other fees incident to transfer of evidence of ownership of a comparable motor vehicle. The actual cost shall be determined by any one (1) of the following:

1. The cost of a comparable motor vehicle in the local market area if a comparable motor vehicle is available in the local market area;

2. If a comparable motor vehicle is not available in the local market area, one (1) of two (2) or more quotations obtained by the insurer from two (2) or more qualified and licensed dealers which engage in the buying and selling of comparable motor vehicles in the ordinary course of their business located within the local market area; or

3. Any source for determining statistically valid fair market values including nationally-recognized automobile evaluation publications that meet all of the following criteria:

a. The source shall give consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

b. The source's data base shall produce values for at least eighty-five (85) percent of all makes and models for the last eight (8) model years taking into account the values of all major options for these vehicles;

c. The source shall produce fair market values based on current data available from the local market area where the insured vehicle was principally garaged or a necessary expansion of parameters such as travel time and area to assure statistical validity;

4. Actual cash value as determined by the use of the source’s database shall be adjusted to reflect any value of enhancements to the motor vehicle not accounted for by the database;

5. If the vehicle’s condition does not meet the criteria for value used in source’s database, the actual cash value amount may be adjusted; and

6. Absent an appraisal provision in the insurance contract, if the insured demonstrates, by presenting two (2) independent appraisals, based on measurable and discernable factors, that the vehicle would have a higher cash value in the local market area than the value reflected in the source’s database, the local market value shall be considered when determining the actual cash value;

(c) Right of recourse. If the insurer is notified within thirty-five (35) days of the receipt of the claim draft that the insured cannot purchase a comparable motor vehicle for market value as defined in paragraph (b)3 of this subsection, the insurer shall reopen its claim file and comply with the following procedures:

1. The insurer may locate a comparable motor vehicle by the same manufacturer, same year, similar body style, and similar options and price range for the insured for the market value determined by the insurer at the time of settlement. This vehicle shall be available through licensed motor vehicle dealers;

2. The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable motor vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this motor vehicle for the insured; or

3. The insurer may conclude the loss settlement as prepared for under the appraisal provision of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or law; or

(d) If a first party motor vehicle's total loss is settled on a basis which deviates from the methods described in subsection (1)(a) and (b) of this section, the deviation shall be supported by documentation giving particulars of the motor vehicle's condition. Any deductions from the cost, including deduction for salvage, shall be measurable, discernable, itemized, and specified as to dollar amount and shall be appropriate in amount. The basis for the alternative method of settlement shall be explained fully to the first party claimant.

(2) The measure of damages in a third-party motor vehicle loss shall be the difference between the fair market value of the motor vehicle immediately before and after the loss, proportioned by the third party's contributory negligence, if any. Repair estimates or appraisers' reports may be used to indicate the difference in fair market value. The measure of damages in a first party vehicle loss shall be governed by the policy of insurance issued to the first party and shall not include any measure of damages not specifically provided for in the policy.

(3) If liability and damages are reasonably clear, insurers shall not recommend that third-party claimants make claims under their own policies, certificates, or contracts solely to avoid paying claims under the insurers' policies, contracts, or certificates.

(4) Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement motor vehicle.

(5) If requested by the claimant, insurers shall include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. Deduction for expenses shall not be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction shall then be for only a pro rata share of the allocated loss adjustment expense.

Section 8. Repairs to Motor Vehicles. (1) If losses involving motor vehicle repairs are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a worker-like manner. If the insured subsequently claims, based upon a written estimate which the insured obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall pay the difference between the written estimate and a higher estimate obtained by the insured, or promptly provide the insured with the name of at least one (1) repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one (1) or two (2) repair shops, the insurer shall assure that the repairs are performed in a worker-like manner. The insurer shall maintain documentation of all of these communications.

(2) If the amount claimed is reduced because of betterment or depreciation, all information for the reduction shall be contained in the claim file. These deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(3)(a) Betterment deductions shall be allowed only if the deductions reflect a measurable decrease in the market value and general overall condition of the motor vehicle.

(b) The deductions set forth in paragraph (a) of this subsection shall be measurable, itemized, specified as to dollar amount, and documented in the claim file.

(c) Insurers shall not require the insured or claimant to supply parts for replacement.

(4) Insurers shall not require the use of replacement crash parts in the repair of a motor vehicle unless the replacement crash part is at least equal in kind and quality to the part to be replaced in terms of fit, quality, and performance. Insurers specifying the use of replacement crash parts shall consider the cost of any modifications which may be necessary when making the repair.

(5) Insurers shall not require a claimant to travel an unreasonable distance:

(a) To obtain a repair estimate; or

(b) To have the motor vehicle repaired at a specific repair shop.

Section 9. Standards for Prompt, Fair, and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage. (1) If the policy, contract, or certificate authorizes the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) If a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment nor any other cost to the extent of replacement cost, except for the applicable deductible.

(b) If a loss requires replacement of items and the replaced items do not reasonably match in quality, color, or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible.

(2) Actual cash value.

(a) If the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at the time of the loss less depreciation, if any. If requested by the insured, the insurer shall provide a copy of the claim file worksheets showing any and all deductions for depreciation.

(b) If the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth in paragraph (a) of this subsection shall not be required. If requested by the insured, the insurer shall provide a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy. (19 Ky.R. 340; Am. 783; 1380; eff. 12-9-92; 28 Ky.R. 709; 1136; eff. 11-12-2001.)