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DEPARTMENT OF INSURANCE

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Regulatory Bulletin 2003-09*

TO: All Property and Casualty Insurers Authorized to Transact in Arizona, Insurance Trade Associations, and Other Interested Parties

FROM: Charles R. Cohen
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DATE: July 2, 2003

RE: **Common Areas of Regulatory Non-Compliance in Personal Lines**

To promote compliance with Arizona insurance laws, the Arizona Department of Insurance previously issued Regulatory Bulletin 2000-04 identifying common findings from market conduct examinations and consumer complaints regarding personal lines insurance.

Based on a review of more recent market conduct examinations and consumer complaints, the Department provides the following additional guidance regarding common areas of regulatory non-compliance.

I Automobile Collision and Glass Repairs - Estimate requirements and repair shop referrals

A.A.C. R20-6-801(H)(5) provides that if an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably

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expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops. This rule clearly permits an insurer to utilize and recommend to claimants a network of preferred repair shops. A.A.C. R20-6-801(H)(7) provides that when the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time. If the repair facility of the claimant's choice estimates the cost of the repair at a greater expense than that of the insurer's preferred repair shop, the claimant may be responsible for costs above the preferred shop's estimate. However, an insurer may not require a claimant to go to a particular repair shop.

The Department receives frequent complaints from auto body and glass repair shops claiming that some insurers disparage the work or reputation of repair shops that are not part of the network of preferred repair shops in an effort to direct claimants to preferred shops. Clearly complaints of this nature can be substantially reduced, if not eliminated, if insurers refrain from providing subjective commentary about repair shops. A.R.S. §20-461(A)(6) prohibits insurers from not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. A general business practice of making negative or disparaging statements or inferences motivated by an interest to direct claimants to a particular repair shop is inconsistent with this standard for fair and equitable claim settlements

Pursuant to A.R.S. §20-461(A)(15), if an automobile is going to be repaired using "aftermarket" parts for the replacement of any nonmechanical exterior part, the insurer must provide the claimant with a written notice attached to the repair estimate that "aftermarket" parts are being proposed for use in the repair of the vehicle. The insurer's estimate, in accordance with A.A.C. R20-6-801(H)(5), must be in an amount that can be reasonably expected to satisfactorily repair the damage and restore the vehicle to its pre-collision condition. In the event that hidden damage is discovered after repairs begin, the insurer must adjust the estimate. Sales tax shall be included for all taxable parts or materials. In the course of an examination or resolving a consumer complaint, the Department will review the estimate documentation. Issues relating to reporting and payment of sales tax will be referred to the Arizona Department of Revenue.

II Anti-Theft Devices

The ADOI has received complaints that some automobile insurers may be engaging in unfair claim settlement practices relative to theft claims involving automobiles equipped with sophisticated vehicle security technologies. Generally, these complaints arise out of claim denials involving automobiles that have been reported stolen while the vehicle was equipped with anti-theft technology that purportedly makes it impossible to start or steal the vehicle without the use of a proper key. The ADOI has observed similar claim denials involving such security systems wherein a claim is denied based on the assertion that these vehicles were recovered without damage "noted" to existing

security or locking mechanisms. Insurers may be challenging or denying these claims solely on the presumption that absent damage to the anti-theft system, the car could not have been stolen or started without the use of the owner's key. The insurer concludes that the insured's claim is without merit per se and denies the claim, without the benefit of appropriate confirmation that the security system was not, in fact, damaged, altered or circumvented.

A.R.S. §20-461 requires insurers to conduct a fair and reasonable investigation of each claim, including consideration of all available information relating to the claim. There are many variables in the numerous security systems available to consumers, whether they are factory or aftermarket installations. A fair and reasonable investigation must include a genuine effort to determine the condition, capabilities and limitations of the security system(s) installed on the vehicle in question and if that system was damaged, altered or circumvented. Though a claims investigation may begin with an assessment of the likelihood that the vehicle could have been stolen given that the vehicle was equipped with an anti-theft device, the investigation must progress to an evaluation of all the reasonably available relevant evidence to determine whether or not the anti-theft device was damaged, altered or circumvented. Ideally, based on the technology inherent in these security systems, as well as the level of expertise required to properly examine them, a person with appropriate qualifications should examine the system in question as soon as possible after the vehicle has been recovered. It is feasible that where a vehicle is equipped with an anti-theft device and the anti-theft device was engaged, factual issues may yet exist as to whether a theft claim is valid. For example, the vehicle could have been hauled or towed away from the owner's control, the lock could have been picked or a "jiggle key" used, there may be witnesses that support or contradict the insured's claim, the security system on the vehicle may have previously failed or other circumstances.

If the insurer is unable to obtain any of this information, the claim file should reflect the attempts to obtain the information and an explanation as to why the information was unavailable. An insurer may not establish generic profiles of claims and claimants on the basis of which it makes presumptions about the validity of particular claims, and then rely upon those presumptions, without further investigation, to make and communicate final settlement decisions. If after a full and reasonable investigation, the insurer believes that a fraudulent claim has been or is being made, the insurer shall refer the claim to the Fraud Unit in accordance with A.R.S. §20-466(G). For additional information on making referrals, please refer to the Fraud Unit materials on the Department's web site.

III Auto Total Loss Settlements

A.A.C. R20-6-801(H)(1)(b) requires that when settling first party automobile total losses, an insurer must include all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. These taxes and fees include sales taxes, air quality taxes and license and registration fees. Special attention should be given to the amount of sales taxes to be paid to ensure that all state, county

and municipal taxes applicable in the claimant's local market area are included in the settlement.

When a deductible applies to a total loss claim, the amount of taxes and fees should be calculated based on the total value of the automobile before subtracting the deductible amount.

When a claimant elects to retain the salvage in a total loss, the salvage transaction is a separate transaction from the settlement of the total loss. Taxes and fees should be paid on the total actual cash value ("ACV") of the vehicle. Only after the claim is adjudicated should the salvage amount be deducted from the insurer's claim payment to the claimant.

IV File and Record Documentation

A.A.C. R20-6-801(C) requires insurers to maintain all notes and work papers pertaining to claims in sufficient detail to allow the Department to reconstruct the handling of a claim. If an insurer does not maintain its claim files in sufficient detail, the insurer, in many cases, will be unable to prove that it settled the claim consistent with Arizona law. In the event an insurer has delegated the handling of claims to a third party, the insurer is still obligated to assure the maintenance and availability of records and to produce them to the Department upon request.

V Notice of Information Practices

A.R.S. §20-2104(A) requires insurers or agents to provide a *Notice of Information Practices* to applicants and policyholders in connection with insurance transactions described in the statute. The notice provided may be comprehensive, as described in A.R.S. §20-2104(C), or abbreviated, as described in A.R.S. §20-2104(D). If an insurer chooses to use an abbreviated notice, the comprehensive notice must nevertheless be available in the event an applicant or policyholder requests one.

Though these provisions have been in effect for many years, many insurers continue to use *Notices of Information Practices* that do not meet the minimum requirements described in A.R.S. §20-2104. This law is very specific as to what disclosures must be included in the notice. The Department strongly recommends that insurers carefully review this law to ensure their forms are in compliance.

VI Authorizations to Disclose Information

Similarly, with regard to authorizations to disclose information in connection with an insurance transaction, A.R.S. §20-2106 delineates the disclosures that must be included in the form. The most common problems found during examinations are:

- failure to specify the types of persons authorized to disclose information,
- failure to specify why the information is being collected,
- failure to indicate the duration of the authorization's validity, and

- failure to advise the individual that the individual or a representative authorized by the individual is entitled to receive a copy of the authorization form.

If an authorization to disclose information mentions that an investigative consumer report may be requested, then the authorization must also disclose that the individual may request to be interviewed in connection with any investigative consumer report and is entitled to receive a copy of the report. (A.R.S. §20-2107)

If an authorization references release of HIV-related information from an insurer, then the authorization must be valid for no longer than 180 days regarding any HIV-related information releases. (A.A.C. R20-6-1204(B)(3))

VII Adverse Underwriting Decisions/Summary of Rights

In the event of an adverse underwriting decision, A.R.S. §20-2110(A) requires insurers to either provide the applicant with the specific reason for the adverse underwriting decision in writing, or advise the applicant that the specific reason will be provided to the applicant upon written request. When the reason is being provided, it is insufficient to indicate that an applicant was declined for "underwriting reasons" or some similarly vague description that fails to provide a meaningful explanation of the specific reason for the adverse underwriting decision in the case at hand.

In addition to the specific reason, insurers ***must*** also provide the applicant with a *Summary of Rights* along with the adverse underwriting decision notice. Some insurers apparently misinterpret A.R.S. §20-2110(A) to require a Summary of Rights only upon receipt of a written request from the applicant. Such an interpretation undermines the intent of this law. The *Summary of Rights* must accompany the adverse underwriting decision and must contain a summary of the applicant's rights under A.R.S. §§20-2108, 20-2109 and 20-2110(B).

The required elements of the *Summary of Rights* are very extensive. Insurers should carefully review A.R.S. §§20-2108, 20-2109 and 20-2110.

VIII Personal Auto Insurance Cancellations and Nonrenewals

In the course of an examination or investigation, the Department often identifies improper automobile cancellation and nonrenewal procedures. Insurers may cancel or nonrenew automobile insurance policies that have been in force for 60 days or longer for the reasons listed in A.R.S. §20-1631. No other reasons are permissible. Further, A.R.S. §20-1632.01(A) requires auto insurance policies to include a seven-day grace period for the payment of premium. The policy must stay in full force during the grace period.

If the insurer determines that cancellation or nonrenewal is permissible under Arizona law, the insurer must then send the requisite notice to the insured. Cancellation or

nonrenewal notices for reasons other than nonpayment of premium must be mailed at least ten days prior to the effective date of termination by certified mail or by a post office certificate of mailing. Nonrenewals under A.R.S. §20-1631(E) must be sent at least 45 days prior to the effective date of nonrenewal. (A.R.S. §20-1632(A)). The nonrenewal or cancellation notices must specify the reason(s) for the cancellation, notice of the insured's right to complain to the Director, and notice of possible eligibility for the assigned risk plan. Any refund of unearned premium due the insured must accompany the notice. (A.R.S. §20-1632(A)(1), (2) and (3)). The cancellation is effective on the date the notice is mailed. (A.R.S. §20-1632.01(B)).

If an insurer fails to comply with the notification requirements of A.R.S. §20-1632(A) when canceling or nonrenewing a policy, any such cancellation or nonrenewal is invalid. (A.R.S. §20-1632(B)).

Questions concerning the matters discussed in this Regulatory Bulletin may be addressed to Paul J. Hogan, Chief Market Conduct Examiner (602) 912-8442 or phogan@id.state.az.us.