18 UNFAIR CLAIM SETTLEMENT PRACTICES

Alaska's Unfair Claim Settlement Practices Act, AS 21.36.125, proscribes conduct by insurers in connection with the handling of first and third-party claims that does not result in the prompt and equitable resolution of valid claims. Expressly prohibited are acts and practices constituting misrepresentation of facts or policy provisions, failure to acknowledge and act promptly on communications concerning a claim, refusing to pay a claim without first conducting a reasonable investigation of all of the available information and providing an explanation of the basis of denial, failure to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear, etc.

The Alaska Supreme Court has held that a liability insurer has the legal duty promptly to notify the insured of a coverage dispute.[1] The court held that "the duty to give this notice should not depend on the insurer's final decision on coverage. Rather, it should attach when an insurer has good reason to believe that a coverage dispute may exist." Consequently, insurers are well-advised to provide written notice to their insureds whenever they believe or suspect that there is an applicable exclusion or other basis for denying coverage, and the insurer providing such notice should take pains to expressly cite the applicable exclusion, term or condition in its correspondence. If the insurer fails to provide such notice, and proceeds to interview the insured and to obtain information that supports a claim denial, the insurer may very well be held by the court to be estopped from denying coverage.

The Alaska Supreme Court has held that an insurer cannot be sued by a third-party claimant for alleged violation of the Act.[2] Nevertheless, evidence of violations is admissible in a first party bad faith action as evidence of the insurer's bad faith.[3]

In addition to the statute, Alaska's Division of Insurance has adopted comprehensive regulations designed to implement and effectuate the requirements set forth in the Act. These regulations, set forth in 3 AAC 26.010 *et seq.*, require insurers to maintain careful records pertaining to claims, to document communications with insureds, to respond to communications and claims within set time periods, and to accept or deny claims within certain deadlines and (in the case of denials) with full explanation of the basis of the decision.

Also, AS 21.89.030 requires an insurance company to pay any judgment or settlement of a claim by negotiable bank check **payable on demand**. Payment may

---

[1] *Lloyd & Institute of London Underwriting Cos. v. Fulton*, 2 P.3d 1199, 1204 (Alaska 2000).

[2] *O.K. Lumber Co. v. Providence Wash. Ins. Co.*, 759 P.2d 523 (Alaska 1988).

[3] *State Farm Mut. Auto. Ins. Co. v. Weiford*, 831 P.2d 1264 (Alaska 1992).

not be made by a bank draft. To comply with this provision, insurers must either arrange for settlement funds to be paid out of an account with an Alaska bank, wire transfer the settlement funds directly into the claimant's account, or have a corresponding bank relationship with an Alaska bank.

It is vitally important for insurance adjusters and representatives dealing with Alaskan claims to become fully familiar with the statutory and regulatory obligations imposed upon insurers doing business in Alaska.

The Alaska Supreme Court has held that a liability insurer fails to comply with its defense obligations if, in the context of providing a defense under a reservation of rights, the insurer advises the insured that he/she must pay for their own counsel to protect their interests, or if the insurer refuses unreasonably to pay the insured for a valid claim covered by the policy, or if the insurer fails to conduct a fair investigation that seeks to discover evidence supporting coverage.[4]

The reader is urged to review Tabs 19 and 20 of this summary in conjunction with this Tab, since all of these sections are interrelated.

Appendices:

AS 21.36.125
AS 21.89.030
3 AAC 26.010 – 300

[4] *Great Divide Ins. Co. v. Carpenter, 79 P.3d 599 (Alaska 2003)*(see discussion at Tab 6).

Sec. 21.36.125. Unfair claim settlement practices. [See delayed amendment note.] (a) A person may not commit any of the following acts or practices:

(1) misrepresent facts or policy provisions relating to coverage of an insurance policy;

(2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;

(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

(5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;

(6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;

(7) engage in a pattern or practice of compelling insureds to litigate for recovery of amounts due under insurance policies by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(8) compel an insured or third-party claimant in a case in which liability is clear to litigate for recovery of an amount due under an insurance policy by offering an amount that does not have an objectively reasonable basis in law and fact and that has not been documented in the insurer's file;

(9) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

(10) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;

(11) make a claims payment without including a statement of the coverage under which the payment is made;

(12) make known to an insured or third-party claimant a policy of appealing from an arbitration award in favor of an insured or third-party claimant for the purpose of compelling the insured or third-party claimant to accept a settlement or compromise less than the amount awarded in arbitration;

(13) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

(14) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;

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

(16) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.89.030;

(17) **[Effective July 1, 2001.]** violate a provision contained in AS 21.07.

(b) **[Effective July 1, 2001.]** The provisions of this section do not create or imply a private cause of action for a violation of this section. (§ 6 ch 163 SLA 1976; am §§ 5, 6 ch 97 SLA 2000; am § 3 ch 99 SLA 2000)

Delayed amendment. — Until January 1, 2001, this section reads as follows: "A person may not commit or engage in with such frequency as to indicate a practice any of the following acts or practices:

"(1) misrepresent facts or policy provisions relating to coverage of an insurance policy;

"(2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;

"(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

"(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

"(5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;

"(6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;

"(7) compel insureds to litigate for recovery of amounts due under insurance policies by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

"(8) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

"(9) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;

"(10) make a claims payment without including a statement of the coverage under which the payment is made;

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

"(12) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

"(13) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;

"(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

"(15) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.89.030."

Revisor's notes. — Paragraph (a)(17) was enacted as (16). Renumbered in 2000.

Effect of amendments. — The first 2000 amendment, effective January 1, 2001, in subsection (a) deleted "or engage in with such frequency as to indicate a practice" following "commit" in the introductory language, substituted "engage in a pattern or practice of compelling" for "compel" at the beginning of paragraph (7), added present paragraph (8) and redesignated paragraphs accordingly, and rewrote paragraph (12); and added subsection (b).

The second 2000 amendment, effective July 1, 2001, added paragraph (a)(17).

NOTES TO DECISIONS

A third party claimant has no cause of action against an insurer under this section. O.K. Lumber Co. v. Providence Wash. Ins. Co., 759 P.2d 523 (Alaska 1988).

Punitive damages. — Not all conduct which amounts to the tort of bad faith is sufficiently outrageous to warrant an award of punitive damages. State Farm Mut. Auto. Ins. Co. v. Weiford, 831 P.2d 1264 (Alaska 1992).

Quoted in State Farm Fire & Cas. Co. v. Nicholson, 777 P.2d 1152 (Alaska 1989).

Stated in Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998), cert. denied, 525 U.S. 930, 119 S. Ct. 338, 142 L. Ed. 2d 279 (1998).

Sec. 21.89.030. Payment. An insurance company doing business in this state may not pay a judgment or settlement of a claim in this state for a loss incurred in this state with an instrument other than a negotiable bank check payable on demand and bearing even date with the date of writing or by electronic funds transfer. (§ 1 ch 172 SLA 1968; am § 106 ch 62 SLA 1995)

Revisor's notes. — Enacted as AS 21.89.020. Renumbered in 1968.

NOTES TO DECISIONS

Disposition of recovered penalties. — This section is an administrative tool for the use of the division of insurance, not private parties, and any penalty recoverable for a violation is payable to the state, not the private party who received the instrument. Harper v. K & W Trucking Co., 725 P.2d 1066 (Alaska 1986).

This section concerns only the form of payment which must be used for settling insurance claims, not its effect on an underlying obligation. Harper v. K & W Trucking Co., 725 P.2d 1066 (Alaska 1986).

"Payable through" draft violated section. — A "payable through" draft sent to a workers' compensation claimant in settlement of his claim violated this section because it was not a bank check. Harper v. K & W Trucking Co., 725 P.2d 1066 (Alaska 1986).

ARTICLE 1. UNFAIR CLAIMS SETTLEMENT ACTS OR PRACTICES.

3 AAC 26.010. PURPOSE. (a) The purpose of 3 AAC 26.010 — 3 AAC 26.300 is to define minimum standards for claim settlement acts and practices.

(b) Violation of a standard is an unfair or deceptive act and is prohibited.

(c) Violation of a standard with such frequency as to indicate a general business practice is an unfair or deceptive practice and is prohibited.

(d) Violation of a standard by a person who knew or should have known an act or practice violated the standard is subject to an additional penalty under AS 21.36.320(e). (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.320
AS 21.36.010 AS 21.36.150 AS 21.36.350

3 AAC 26.020. SCOPE. 3 AAC 26.010 — 3 AAC 26.300 apply to all persons transacting a business of insurance who participate in the investigation, adjustment, negotiation, or settlement of a claim under all types of insurance. (Eff. 5/6/89, Register 110)

Authority: AS 21.03.010 AS 21.36.125 AS 21.84.050
AS 21.06.090 AS 21.36.350 AS 21.87.020
AS 21.33.011 AS 21.75.310 AS 21.88.010
AS 21.36.020 AS 21.76.020

3 AAC 26.030. FILE AND RECORD DOCUMENTATION. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim under any type of insurance must document each action taken on a claim. The documentation must contain all notes, work papers, documents and similar material. The documentation must be in sufficient detail that relevant events, the dates of those events, and all persons participating in those events can be identified. The documentation may include legible copies of originals and may be stored in the form of microfilm or electronic media. The documentation is subject to examination and copying by the director or persons acting on the director's behalf. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.090 AS 21.36.350
AS 21.06.120 AS 21.36.125 AS 21.36.410
AS 21.06.130

3 AAC 26.040. REQUIRED CLAIM COMMUNICATION. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim must:

(1) within 10 working days after receipt of notification of a claim, give written acknowledgement to the first-party claimant identifying the person handling the claim, including the person's name, address, telephone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

(2) within 15 working days after receipt, make an appropriate reply to all other communications from a first-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

(3) upon receipt of notification of a claim, promptly provide necessary claim forms, instructions, and assistance so that the first-party claimant is able to comply with legal, policy, or contract provisions and other reasonable requirements.

(b) Any person transacting a business of insurance who participates in the investigations, adjustment, negotiation, or settlement of a third-party claim must:

(1) within 10 working days after notification of the claim from a third-party claimant, give written acknowledgement to the third-party claimant, identifying the person handling the claim, including the person's name, address, phone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

(2) within 15 working days after receipt, make an appropriate reply to all other communications from a third-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

(3) upon receipt of notification of a claim from a third-party, promptly provide necessary claim forms, instructions and assistance that is reasonable so that the third-party claimant is able to comply with any reasonable requirement;

(4) within 10 working days after notification of a claim received from or on behalf of an insured, give written acknowledgement to the insured, identifying the person handling the claim, including the person's name, mailing address, telephone number, the firm name, and the file number; notification of a claim to an agent constitutes notification to the principal.

(c) If notification of a claim is received in the form of a suit, a demand for arbitration, application for adjudication, or other pleading, any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall comply with the rules of that particular forum rather than this section only so long as the claim is pending in that forum. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.050. STANDARDS FOR PROMPT INVESTIGATION OF CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall promptly undertake the investigation of a claim after notification of the claim is received, and shall complete the investigation within 30 working days, unless the investigation cannot reasonably be completed using due diligence.

(b) Unless the notification of a claim is in the form of a suit, demand for arbitration, application for adjudication, or other pleading, or the claim becomes the subject of such litigation within 30 working days, the person transacting the business of insurance shall give written notification to the claimant that specifically states the need and reasons for additional investigative time and also specifies the additional time required to complete the investigation. That notification shall be given no later than the 30th working day after notification of the claim is first received. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.060. DISCLOSURE AND REPRESENTATION OF COVERAGE PROVISIONS. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim:

(1) shall fully disclose to a first-party claimant all relevant benefits and other provisions of coverage under which a claim may be covered;

(2) may not deny a claim on the ground that the first-party claimant failed to exhibit the property without written proof of demand and the unwarranted delay or refusal by the first-party claimant to do so;

(3) may not, except where there is a time limit specified in the coverage document, make statements, written or otherwise, requiring a first-party claimant to give written notice of loss, statement of claim, proof of loss, or similar affidavit within a specified time limit;

(4) may not request a first-party claimant to agree to a compromise or enter into a release that extends beyond the subject matter that gives rise to the claim payment; and

(5) may not issue a check, draft, warrant or other claim payment in partial settlement of a loss or claim under a specified coverage, which contains language that releases or compromises the issuer or its principal from any other liability. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.070. STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim:

(1) shall advise a first-party claimant in writing of the acceptance or denial of the claim within 15 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss unless another time limit is specified in the insurance policy, insurance contract, or other coverage document; payment of the claim within this time limit constitutes written acceptance; a written denial of the claim must state the specific provisions, conditions, exclusions, and facts upon which the denial is based; if additional time is needed to determine whether the claim should be accepted or denied, written notification giving the reasons that more time is needed shall be given to the first-party claimant within the deadline. While the investigation remains incomplete, additional written notification shall be provided 45 working days from the initial notification, and no more than every 45 working days thereafter giving the reasons that additional time is necessary to complete the investigation; if there is a reasonable basis supported by specific information for suspecting that a first-party claimant has fraudulently caused or wrongfully contributed to the loss, and the basis is documented in the claim file, this reason need not be included in the written request for additional time to complete the investigation or the written denial; however, within a reasonable time for completion of the investigation and after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, the first-party claimant shall be advised in writing of the acceptance or denial of the claim;

(2) shall, within 30 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, pay those portions of the claim not in dispute;

(3) may not fail to settle first-party claims on the basis that responsibility for payment must be assumed by others, except as may be expressly provided by provisions of the insurance policy, insurance contract, or other coverage document.

(b) A person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party claim may not make any statement that indicates that the rights of a third-party claimant may be impaired if a form, compromise, release, or similar document is not completed within a given period of time, unless the statement is given for the purpose of notifying the third-party claimant of an applicable statute of limitation.

(c) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim may not continue negotiations for settlement of the claim directly with any claimant who is neither an attorney nor represented by an attorney to a time when the claimant's rights might be affected by a statute of limitation, coverage provision, or other time limit, unless written notice is given to the claimant clearly stating the time limit that might be expiring and its effect upon the claim; such a written notice shall be given at least 60 calendar days before the date on which the time limit might expire.

(d) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall pay a judgment or settlement of the claim (including advances, partial settlements, or similar payments) with a negotiable check payable in cash to the payee upon presentation to a bank located in Alaska. If the check is not drawn upon a bank having a physical location in Alaska, it must be payable in cash upon presentation to at least one bank having a physical location in Alaska. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.350 AS 21.89.030

3 AAC 26.080. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF MOTOR VEHICLE CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party motor vehicle claim must:

(1) apply one of the following settlement methods if coverage provides for the adjustment of a motor vehicle total loss on the basis of actual cash value or replacement with a vehicle of like kind and quality:

(A) offer a comparable and available replacement motor vehicle, with all applicable taxes, license fees, destination or delivery charges, and other fees incident to transfer of ownership of the motor vehicle paid, at no cost to the first-party claimant other than the deductible amount, if any, as stated in the coverage; the offer of a replacement motor vehicle shall be made in writing if rejected by the first-party claimant; or

(B) make a cash settlement based upon the actual cost to purchase a comparable motor vehicle, including all applicable taxes, license fees, destination or delivery charges, and other fees incident to transfer of ownership, less the deductible amount, if any, as stated in the coverage; the cost shall be determined by:

(i) the cost of a comparable motor vehicle in the local market area to the claimant, if that motor vehicle is available in that area; or

(ii) the average of two or more cost quotations obtained for a comparable motor vehicle from two or more qualified dealers located within the local market area, if a comparable motor vehicle is not available in that area; or

(iii) a basis that is allowable under the coverage but deviates from the rules set out in (i) and (ii) of this subparagraph, if the deviation is supported by documentation in the claim file which gives the particulars of the condition of the motor vehicles involved; any deduction from the cost of a comparable motor vehicle, including deduction for salvage value, must be a fair and appropriate amount; the basis for the deduction shall be fully explained to the claimant;

(2) provide to a first-party claimant a reasonable written explanation of the valuation of damages to the motor vehicle;

(3) include the first-party claimant's deductible, if any, in a subrogation demand unless the first-party claimant requests that it not be included or unless the deductible has been otherwise recovered by the first-party claimant; no deduction for expense may be made from any deductible recovered unless an outside attorney or other outside expert witnesses have been retained and any deduction is no more than a pro rata share of their cost less any attorney fees and costs recovered; any recovery of prejudgement or postjudgement interest shall be shared pro rata.

(b) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party motor vehicle claim:

(1) shall provide a third-party claimant a reasonable written explanation of the valuation of damages to a motor vehicle which is the basis of any settlement offer;

(2) may not recommend that a third-party claimant make a claim under the claimant's own coverage in order to delay or avoid paying a claim where liability and damages are reasonably clear.

(c) A claimant may not be required to travel unreasonably either to inspect a replacement motor vehicle, obtain a repair estimate, or have the motor vehicle repaired at a specific facility.

(d) Any estimate or appraisal of the cost of repair of a motor vehicle must be in a fair and appropriate amount that the claimant may reasonably be expected to be charged for repairs at one or more conveniently located repair facilities.

(e) If the amount claimed as damage to the motor vehicle is reduced on the basis of betterment or depreciation, the person adjusting or settling the claim shall itemize each deduction and explain the basis for each reduction in writing to the claimant.

(f) If a person adjusting or settling a claim elects to have repaired a claimant's motor vehicle and chooses a specific facility for the repairs, that person shall guarantee the repairs and cause the damaged motor vehicle to be restored to its condition before the loss, at no additional cost to the claimant, and cause the repairs to be completed within a reasonable time.

(g) If the claimant's motor vehicle is determined to be economically unrepairable and, therefore, a total loss, the person adjusting or settling the claim may not reduce the salvage value of the vehicle by charges for cleaning. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.090. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF PROPERTY CLAIMS. (a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party property claim shall:

(1) apply one of the following settlement methods if coverage provides for the adjustment of a claimant's property loss on the basis of actual cash value or replacement with other property of like kind and quality;

(A) offer specific comparable and available replacement property, with all applicable taxes, charges, and other fees incident to the transfer of ownership of the property at no cost to the claimant other than the deductible amount, if any, as stated in the coverage; the offer of replacement property shall be in writing if rejected by the first-party claimant; or

(B) make a cash settlement based upon the actual cost of comparable property, including all applicable taxes, charges and other fees incident to transfer of ownership, less the deductible amount, if any, as stated in the coverage; the cost shall be determined by:

(i) the cost of comparable property in the local market area to the claimant, if such property is available in that area; or

(ii) the average of two or more cost quotations obtained for comparable property from two or more qualified dealers, suppliers or contractors located within the local market area, if comparable property is not available in that area; or

(iii) settle a loss on a basis that deviates from the rules set out in (i) and (ii) of this subparagraph, if the deviation is supported by documentation in the claim file which gives the particulars of the condition of the property involved; the valuation, including salvage value of the property lost, if any, must be in an adequate and appropriate amount; the basis for settlement shall be fully explained to the claimant;

(2) provide to a first-party claimant a reasonable written explanation of the valuation of the damages to the property;

(3) include the first-party claimant's deductible, if any, in a subrogation demand unless the first-party claimant requests that it not be included or unless the deductible has been otherwise recovered by the first-party claimant; no deduction for expense may be made from any deductible recovered unless an outside attorney or other outside expert witnesses have been retained and deduction may be for no more than a pro rata share of their cost less attorney fees and costs recovered; any recovery of prejudgement or postjudgement interest shall be shared pro rata.

(b) Any person transacting the business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party property claim:

(1) shall provide to a third-party claimant a reasonable written explanation of the valuation of damages to property which is the basis of any settlement offer;

(2) may not recommend that a third-party claimant make a claim under the claimant's own coverage in order to delay or avoid paying a claim where liability and damages are reasonably clear.

(c) Any person settling or adjusting a property claim may not require a claimant to travel unreasonably either to inspect replacement property, obtain a repair estimate, or have the property repaired at a specific facility.

(d) Any estimate of the costs of the repair of the property must be a fair and appropriate amount for which the damage can be reasonably expected to be repaired at one or more conveniently located repair facilities, dealers, or contractors.

(e) Any person who reduces the amount claimed as damage to property on the basis of betterment or depreciation shall itemize each deduction. The basis for the reduction shall be documented in the claim file.

(f) If a person adjusting or settling a claim elects to have repaired a claimant's property and chooses a specific repair facility, dealer, or

contractor, that person shall guarantee the repairs and cause the damaged property to be restored to its condition before the loss, at no additional cost to the claimant, and cause the repairs to be completed within a reasonable period of time. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.100. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF WORKERS' COMPENSATION CLAIMS. Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a workers' compensation claim:

(1) may not require a claimant to travel unreasonably for medical care, rehabilitation services, or any other purpose;

(2) shall provide necessary claim forms, written instructions, and assistance that is reasonable so that any claimant not represented by an attorney is able to comply with the law and reasonable claims handling requirements;

(3) shall promptly make all payments or denials of payments as required by statute or regulation. (Eff. 5/6/89, Register 110)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350

3 AAC 26.110. ADDITIONAL STANDARDS FOR PROMPT, FAIR, AND EQUITABLE SETTLEMENTS OF HEALTH CLAIMS. (a) If a health insurance policy or a subscriber contract provides for payment of a claim on the basis of services provided by a medical care provider using a usual, customary and reasonable, or prevailing charge basis, a person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim must:

(1) maintain or use a statistically credible profile of medical care providers' charges on which to base payment of claims, which is updated at least every six months and contains charges for services performed not more than one year before the date of the most recent profile; the profile must contain charges for each geographical area in which a claimant might receive treatment; if the profile does not contain a statistically credible data base for a particular medical care service in a certain geographical area, the insurer may include in the profile a sufficient number of charges for that service from another geographical area so that a reliable basis is established; however, the final basis for payment shall be adjusted to reflect the general cost differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile; the adjustment may be based on the Consumer Price Index, the medical care component of the Consumer Price Index, or another reasonable basis stated in

writing; the written explanation provided to a claimant must include a complete explanation of these adjustments;

(2) provide to the claimant, in writing, a complete explanation of the basis of payments and document the explanation in the claim file; if the basis for payment is less than the actual charge made by the medical care provider, the explanation to the claimant must state with specificity the reason for the amount not paid.

(b) This section does not apply to workers' compensation claims.

(c) If a person who is required to include a coordination of benefits provision under AS 21.42.205 provides coverage on a secondary basis,

(1) absent evidence of fraud, the secondary insurer must accept the primary insurer's precertification, utilization review, or other managed care requirement determination and may not deny, delay, or reduce benefits under its policy for a covered person who has met the primary insurer's precertification, utilization review, or other managed care requirement; and

(2) the secondary insurer must calculate its covered benefits at no greater cost to the covered person than if the health care services were obtained from the secondary insurer's participating provider if

(A) the secondary policy provides benefits through a provider network but the primary insurer's policy does not provide coverage through a provider network;

(B) both the primary policy and the secondary policy provide benefits through provider networks but the covered person obtains health care services from a provider that is in the provider network of the primary insurer but not the provider network of the secondary insurer; or

(C) both the primary policy and the secondary policy provide benefits through provider networks but the covered person obtains health care services from a provider that is not part of the provider network of the primary insurer or the secondary insurer because no provider in the primary insurer's provider network is able to meet the particular health need of the covered person. (Eff. 5/6/89, Register 110; am 4/20/97, Register 142; am 1/2/98, Register 145)

Authority: AS 21.06.090 AS 21.36.350 AS 21.42.205
AS 21.36.125

3 AAC 26.300. DEFINITIONS. In this chapter,

(1) "claim" means notice that an event, act or omission has occurred which may result in injury or damage for which an insured may be legally obligated to pay;

(2) "claimant" means a first-party claimant, a third-party claimant, or both, and includes the claimant's legal representative and includes a member of the claimant's immediate family if authorized by the claimant;

(3) "Consumer Price Index" means the data published annually in the Detailed Report by the United States Department of Labor, Bureau of Labor Statistics;

(4) "destination or delivery charges" means the charges for shipping a motor vehicle to a primary residence of the claimant or to where the motor vehicle is primarily operated;

(5) "first-party claimant" means a person asserting a right to payment under his or her own coverage;

(6) "frequency as to indicate a general business practice" means violation of any one standard committed on one or more percent of claims handled within a 12-month period, or the repeated violation of a single standard without reasonable explanation;

(7) "local market area" means the geographical area, in the closest proximity to the claimant's residence, in which two or more qualified dealers are located;

(8) "outside attorney" means an attorney who is in private practice and not an employee of a person transacting a business of insurance under AS 21;

(9) "person" means an individual, corporation, association, partnership, or other legal entity;

(10) "third-party claimant" means any person asserting a claim against any other person;

(11) "usual, customary, and reasonable, or prevailing charge basis" means that payment basis for a health insurance claim where the reasonable and prevailing charge for a medical care procedure, service, or supply item is determined by the lowest of the following amounts:

(A) the billed amount of the medical care provider's actual charges;

(B) the charge usually made by that provider for performing that procedure; or

(C) the customary charge based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or have provided the same supply item;

(12) "working days" means all calendar days except Saturdays, Sundays, all official federal holidays, and all official Alaska holidays. (Eff. 5/6/89, Register 110; am 4/20/97, Register 142)

Authority: AS 21.06.090 AS 21.36.125 AS 21.36.350