

State of Arkansas  
89th General Assembly  
Regular Session, 2013

# A Bill

HOUSE BILL 2099

By: Representative Lowery

## For An Act To Be Entitled

AN ACT TO ESTABLISH THE ARKANSAS INSURANCE FAIR  
CONDUCT ACT; AND FOR OTHER PURPOSES.

### Subtitle

TO ESTABLISH THE ARKANSAS INSURANCE FAIR  
CONDUCT ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 66, is amended to add an additional subchapter to read as follows:

#### Subchapter 8 – Arkansas Insurance Fair Conduct Act

##### 23-66-801. Title.

This subchapter shall be known and may be cited as the "Arkansas Insurance Fair Conduct Act".

##### 23-66-802. Definitions.

###### As used in this subchapter:

(1) "Complaint" means a written communication primarily expressing a grievance;

(2) "Failure to maintain complaint handling procedures" means the failure by a person to adopt and maintain reasonable standards for the prompt handling of complaints received from an insured, claimant, or the Insurance Commissioner on behalf of an insured or claimant;

(3) "First-party claimant" means an individual, corporation,



association, partnership, or entity asserting a right to payment as a covered person under an insurance policy arising out of the occurrence of the contingency or loss covered by the insurance policy;

(5) "Insurance policy" means an individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state;

(6) "Misrepresentation of an insurance policy" means making, issuing, circulating, or causing to be made, issued, or circulated, a pertinent fact or insurance policy provision relating to the coverage at issue, that:

(A) Misrepresents the benefits, advantages, conditions, or terms of an insurance policy;

(B) Uses a name or title of an insurance policy or class of insurance policies, misrepresenting its true nature;

(C) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy; and

(D) Is a misrepresentation for the purpose of effectuating a pledge, assignment of, or a loan against an insurance policy;

(7)(A) "Person" means an individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's plan insurer, fraternal benefit society, or other entity engaged in the business of insurance, including without limitation agents, brokers, and adjusters.

(B) "Person" does not include health carriers, health plans, or medical service plans or hospital service plans as defined in § 23-75-101;

(8) "Standards for the prompt investigation of claims" means the reasonable standards that a person adopts and maintains for exercising reasonable and ordinary care in investigating claims efficiently;

(9) "Standards for prompt, fair, and equitable settlements" means the reasonable standards a person adopts and maintains for exercising reasonable and ordinary care in settling claims in the public interest; and

(10) "Unfair claims settlement practices" means committing or performing with a frequency that indicates a general business practice and without exercising reasonable and ordinary care any of the following:

(A) Misrepresenting an insurance policy;

- (B) Failing to maintain complaint handling procedures;
- (C) Failing to adopt and implement reasonable standards for the prompt investigation of claims;
- (D) Refusing to pay claims without conducting a reasonable investigation;
- (E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed or within the time specified in the insurance policy;
- (F) Not attempting to effectuate prompt, fair, and equitable settlements of claims in which liability is reasonably clear;
- (G) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;
- (H) Making claim payments to policyholders or beneficiaries without a statement that clearly states the coverage under which payments are being made;
- (I) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either, to submit a preliminary claim report and then the subsequent submission of a formal proof of loss form;
- (J) Failing to promptly provide a reasonable explanation of the basis for denial of a claim or an offer of a compromise settlement in the insurance policy;
- (K) Compelling an insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in an action brought by an insured;
- (L) Attempting to settle a claim for less than the amount that a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;
- (M) Making known to an insured or a claimant a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises for less than the amount awarded in arbitration;
- (N) Failing to promptly settle claims, when liability has become reasonably clear, under one (1) portion of the insurance policy

coverage in order to influence settlements under other portions of the insurance policy coverage; and

(O) Requiring as a condition of payment of a claim that repairs must be made by a specific contractor, supplier, or repair shop.

23-66-803. Authority in addition to existing law.

The authority of the Insurance Commissioner under this subchapter is in addition to powers of the commissioner to order restitution or enforce a penalty, fine, or forfeiture authorized by the insurance laws of this state.

23-66-804. Unreasonable denial of claim or benefit.

(a) A first-party claimant to an insurance policy that is unreasonably denied a claim for coverage or payment of benefits or been subject to unfair claims settlement practices of an insurer or insurance company may bring an action in this state to recover:

- (1) The actual damages sustained;
- (2) The costs of the action;
- (3) Reasonable attorney's fees; and
- (4) Litigation costs.

(b) After finding that an insurer or insurance company has acted unreasonably, negligently, or without exercising reasonable and ordinary care in denying a claim or benefits or has used unfair claims settlement practices, a court:

(1) May increase the total award of damages to an amount not more than three (3) times the actual damages; and

(2) Shall award to the prevailing first-party claimant reasonable attorney's fees and actual and statutory litigation costs, including expert witness fees.

(c) An insurer or insurance company has unreasonably denied a claim if it:

- (1) Fails to act in good faith;
- (2) Uses unfair claims settlement practices;
- (3) Misrepresents an insurance policy;
- (4) Fails to acknowledge pertinent communications;
- (5) Fails to promptly investigate claims; or
- (6) Fails to maintain standards for prompt, fair, and equitable

settlements applicable to insurers.

(d) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(e) This section does not apply to a health plan offered by a health carrier or a hospital and medical service corporation as defined in § 23-75-101.

23-66-805. Procedure for payment — Demand.

(a)(1) Twenty (20) days before filing an action under this subchapter, a first-party claimant shall provide to the insurer or insurance company and to the Insurance Commissioner written notice by regular mail of the basis for the cause of action.

(2) The insurer or insurance company and the commissioner are deemed to have received notice three (3) business days after the notice is mailed.

(b) The first-party claimant may bring an action against an insurer or insurance company after the expiration of the twenty-day time period if the insurer or insurance company fails to resolve the matter that is the basis for the action.

23-66-806. Unfair practices in general – Remedies and penalties.

(a) A person shall not engage in unfair claims settlement practices or deceptive acts or practices in the person's insurance business as such methods, acts, or practices are defined under subsection (b) of this section.

(b)(1) In addition to the unfair or deceptive acts or practices defined and prohibited by the insurance laws of this state, the Insurance Commissioner may define other acts and practices in the conduct of the insurance business to be unfair or deceptive through regulation.

(2) In defining other acts and practices in the conduct of the insurance business to be unfair or deceptive, the commissioner shall identify in the rule the basis for defining the act or practice in the conduct of insurance to be unfair or deceptive.