HOUSE BILL NO. 656

AN ACT TO CREATE THE "UNFAIR CLAIMS SETTLEMENT PRACTICES ACT"; TO SET FORTH STANDARDS FOR THE INVESTIGATION AND DISPOSITION OF CLAIMS ARISING UNDER POLICIES OR CERTIFICATES OF INSURANCE; TO PROVIDE DEFINITIONS OF UNFAIR CLAIMS PRACTICES; TO PROVIDE HEARING PROCEDURES; TO PROVIDE PENALTIES FOR VIOLATIONS OF THIS ACT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This act shall be known and may be cited as the "Unfair Claims Settlement Practices Act."

SECTION 2. The purpose of this act is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of Mississippi. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this act.

SECTION 3. When used in this act:

(a) "Commissioner" means the Commissioner of Insurance of this state.

(b) "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

(c) "Insurer" means any person, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators.

Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health
service plans. For purposes of this act, these foregoing entities shall be deemed to be engaged in the business of insurance.

(d) "Person" means any natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

(e) "Policy" or "certificate" means any contract of insurance, indemnity, medical, health or hospital service or annuity issued. "Policy" or "certificate" for purposes of this act, shall not mean contracts of workers' compensation, fidelity, suretyship or boiler and machinery insurance.

SECTION 4. It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any act defined in Section 4 of this act if:

(a) It is committed flagrantly and in conscious disregard of this act or any rules promulgated hereunder; or

(b) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

SECTION 5. Any of the following acts by an insurer, if committed in violation of Section 3, of this act, constitutes an unfair claims practice:

(a) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(b) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(c) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(d) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
(e) Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(f) Refusing to pay claims without conducting a reasonable investigation;

(g) Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

(h) Attempting to settle or settling claims for less than the amount so that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

(j) Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

(k) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

(l) Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;

(m) Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;
(n) Failing to adopt and implement reasonable standards
to assure that the repairs of a repairer owned by or required to
be used by the insurer are performed in a workmanlike manner.

SECTION 6. Whenever the commissioner has reasonable cause to
believe that any insurer doing business in this state is engaging
in any unfair claims practice and that a proceeding in respect
thereto would be in the public interest, the commissioner shall
issue and serve upon such insurer a statement of the charges in
that respect and a notice of hearing thereon, which notice shall
set a hearing date not less than thirty (30) days from the date of
the notice.

SECTION 7. If, after hearing, the commissioner finds an
insurer has engaged in an unfair claims practice, the commissioner
shall reduce the findings to writing and shall issue and cause to
be served upon the insurer charged with the violation a copy of
the findings and an order requiring such insurer to cease and
desist from engaging in the act or practice and the commissioner
may, at the commissioner's discretion, order:

(a) Payment of a monetary penalty of not more than One
Thousand Dollars ($1,000.00) for each violation but not to exceed
an aggregate penalty of One Hundred Thousand Dollars ($100,000.00)
unless the violation was committed flagrantly and in conscious
disregard of this act, in which case the penalty shall not be more
than Twenty-five Thousand Dollars ($25,000.00) for each violation,
but not to exceed an aggregate penalty of Two Hundred Fifty
Thousand Dollars ($250,000.00) pursuant to any such hearing; or

(b) Suspension or revocation of the insurer's license

if the insurer knew or reasonably should have known it was in
violation of this act, or both penalty and suspension or
revocation of the license.

SECTION 8. Any insurer which violates a cease and desist
order of the commissioner while such order is in effect, after
notice and hearing and upon order of the commissioner, may be subject, at the discretion of the commissioner, to:

(a) A monetary penalty of not more than Twenty-five Thousand Dollars ($25,000.00) for each and every act or violation not to exceed an aggregate of Two Hundred Fifty Thousand Dollars ($250,000.00) pursuant to any such hearing; or

(b) Suspension or revocation of the insurer's license or both penalty and suspension or revocation of the license.

SECTION 9. The commissioner, after notice and hearing, may promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this act. Such regulations shall be subject to review in accordance with Section 25-43-1 et seq.

SECTION 10. If any provision of this act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the act, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

SECTION 11. This act shall take effect and be in force from and after July 1, 2001.