

State of South Dakota

EIGHTY-NINTH SESSION
LEGISLATIVE ASSEMBLY, 2014

400V0421

HOUSE BILL NO. 1054

Introduced by: The Committee on Judiciary at the request of the Department of Labor and Regulation

1 FOR AN ACT ENTITLED, An Act to establish consumer protection standards regarding certain
2 insurance claim practices and to provide for certain penalties.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

4 Section 1. Terms used in this Act mean:

5 (1) "Beneficiary," the party entitled to receive the proceeds or benefits occurring under
6 the policy in lieu of the insured;

7 (2) "Claim agent," any individual, corporation, association, partnership, or other legal
8 entity authorized to represent an insurer with respect to a claim;

9 (3) "Claim file," any retrievable electronic file, paper file, or combination of both;

10 (4) "Claim investigation," all activities of an insurer directly or indirectly related to the
11 determination of liabilities under coverages afforded by an insurance policy or
12 insurance contract;

13 (5) "Claimant," either a first party claimant, a third party claimant, or both. The term also
14 includes the insured, the beneficiary or claimant's designated legal representative, and
15 a member of the insured or claimant's immediate family designated by the claimant



- 1 or the insured, making a claim under a policy;
- 2 (6) "Director," the director of the South Dakota Division of Insurance;
- 3 (7) "Documentation," includes all pertinent communications, transactions, notes, work
4 papers, claim forms, bills, and explanation of benefits forms relative to the claim;
- 5 (8) "First party claimant," an individual, corporation, association, partnership, or other
6 legal entity asserting a right to payment under an insurance policy or insurance
7 contract arising out of the occurrence of the contingency or loss covered by the policy
8 or contract;
- 9 (9) "Insured," the party named on a policy or certificate as the individual with legal rights
10 to the benefits provided by the policy;
- 11 (10) "Insurer," a person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal
12 benefit society, and any other legal entity engaged in the business of insurance,
13 including claim agents, brokers, adjusters, and third party administrators. The term
14 also includes medical service plans, hospital service plans, health maintenance
15 organizations, prepaid limited health care service plans, dental plans, and optometric
16 plans;
- 17 (11) "Person," a natural or artificial entity, including individuals, partnerships,
18 associations, trusts, or corporations;
- 19 (12) "Policy" or "certificate," a contract of insurance, indemnity, medical, health, or
20 hospital service, or annuity issued. The term does not include contracts of workers'
21 compensation, fidelity, suretyship, or boiler and machinery insurance;
- 22 (13) "Proof of loss," written proof, including claim forms, medical bills, medical
23 authorizations, or other reasonable evidence of the claim that is ordinarily required
24 of all insureds or beneficiaries submitting the claims;

1 (14) "Reasonable explanation," information sufficient to enable the insured or beneficiary
2 to compare the allowable benefits with policy provisions and determine whether
3 proper payment has been made;

4 (15) "Replacement crash part," sheet metal or plastic parts which generally constitute the
5 exterior of a motor vehicle, including inner and outer panels; and

6 (16) "Third party claimant," any person asserting a claim against any person under a
7 policy or certificate of an insurer.

8 Section 2. The provisions of this Act set forth standards for claim investigation and
9 disposition of claims arising under policies or certificates of insurance issued to residents of
10 South Dakota. It does not apply to claims involving workers' compensation, fidelity, suretyship,
11 or boiler and machinery insurance. Nothing in this Act may be construed to create or imply a
12 private cause of action for violation of this Act.

13 Section 3. It is an improper claims practice for an insurer transacting business in this state
14 to commit an act defined in section 4 of this Act if:

15 (1) It is committed flagrantly and in conscious disregard of the provisions of this Act or
16 any rules promulgated pursuant to this Act; or

17 (2) It is committed with such frequency as to indicate a general business practice to
18 engage in that type of conduct.

19 Section 4. Any of the following acts by an insurer, if committed in violation of section 3 of
20 this Act, is an unfair claims practice:

21 (1) Knowingly misrepresents to claimants and insureds relevant facts or policy
22 provisions relating to coverages at issue;

23 (2) Fails to acknowledge with reasonable promptness pertinent communications with
24 respect to claims arising under its policies;

- 1 (3) Fails to adopt and implement reasonable standards to promptly complete claim
2 investigations and settlement of claims arising under its policies;
- 3 (4) Fails to make a good faith attempt to effectuate prompt, fair, and equitable settlement
4 of claims submitted in which liability has become reasonably clear;
- 5 (5) Compels an insured or beneficiary to institute a suit to recover an amount due under
6 its policies by offering substantially less than the amounts ultimately recovered in a
7 suit brought by the insured or beneficiary;
- 8 (6) Refuses to pay claims without conducting a reasonable claim investigation;
- 9 (7) Fails to affirm or deny coverage of claims within a reasonable time after having
10 completed a claim investigation related to the claim;
- 11 (8) Attempts to settle a claim for less than the amount that a reasonable person would
12 believe the insured or beneficiary is entitled by reference to written or printed
13 advertising material accompanying or made part of an application;
- 14 (9) Attempts to settle a claim on the basis of an application that was materially altered
15 without notice to, or knowledge or consent of, the insured;
- 16 (10) Makes a claim payment to an insured or beneficiary without indicating the coverage
17 under which each payment is being made;
- 18 (11) Unreasonably delays a claim investigation or payment of a claim by requiring both
19 a formal proof of loss form and subsequent verification that would result in
20 duplication of information and verification appearing in the formal proof of loss
21 form;
- 22 (12) Fails, in the case of a claim denial or offer of compromise settlement, to promptly
23 provide a reasonable and accurate explanation of the basis for such actions; and
- 24 (13) Fails to provide forms necessary to present a claim within fifteen days of a request

1 with reasonable explanations regarding their use.

2 Section 5. If the director has reasonable cause to believe that an insurer doing business in
3 this state is engaging in any unfair claims practice and that a proceeding in respect thereto would
4 be in the public interest, the director may issue and serve upon the insurer a notice of hearing,
5 which shall set a hearing date not less than thirty days from the date of the notice. The hearing
6 shall be conducted pursuant to chapter 1-26.

7 Section 6. If, after the hearing, the director finds an insurer has engaged in an unfair claims
8 practice, the director shall reduce the findings to writing and shall issue and serve the insurer
9 a copy of the findings and an order requiring the insurer to cease and desist from engaging in
10 the act or practice. The director may, at the director's discretion, order either or both of the
11 following:

12 (1) The insurer to pay a monetary penalty of not more than one thousand dollars for each
13 violation but not to exceed an aggregate penalty of one hundred thousand dollars,
14 unless the violation was committed flagrantly and in conscious disregard of this Act,
15 in which case the penalty may not be more than twenty-five thousand dollars for each
16 violation, but not to exceed an aggregate penalty of two hundred and fifty thousand
17 dollars; and

18 (2) Suspension or revocation of the insurer's license if the insurer knew or reasonably
19 should have known it was in violation of this Act.

20 This section only applies to violations of this Act.

21 Section 7. If, after an insurer denies a claim, the claimant objects to such denial in writing,
22 the insurer shall notify the claimant in writing that he or she may have the matter reviewed by
23 the South Dakota Division of Insurance.

24 Section 8. No insurer may continue negotiations for settlement of a claim directly with a

1 claimant who is not legally represented, if the claimant's rights may be affected by a statute of
2 limitations, unless the insurer has given the claimant written notice of the limitation. The insurer
3 shall give notice to first party claimants at least thirty days and third party claimants at least
4 sixty days before the date on which the time limit may expire.

5 Section 9. No insurer may make statements indicating that the rights of a third party
6 claimant may be impaired if a form or release is not completed within a given period of time
7 unless the statement is given for the purpose of notifying the third party claimant of the
8 provision of a statute of limitations.

9 Section 10. The failure of a life or health insurer to abide by any of the following standards
10 is an unfair claims practice:

11 (1) The insurer's standards for claims processing shall be such that notice of claim or
12 proof of loss submitted against one policy issued by that insurer shall fulfill the
13 insured's obligation under any and all similar policies issued by that insurer and
14 specifically identified by the insured to the insurer to the same degree that the same
15 form would be required under any similar policy. If additional information is required
16 to fulfill the insured's obligation under similar policies, the insurer may request the
17 additional information. If it is apparent to the insurer that additional benefits would
18 be payable under an insured's policy upon additional proofs of loss, the insurer shall
19 communicate to and cooperate with the insured in determining the extent of the
20 insurer's additional liability;

21 (2) The insurer shall affirm or deny liability on claims within a reasonable time and shall
22 offer payment in compliance with all applicable statutes. If portions of the claim are
23 in dispute, the insurer shall tender payment for those portions that are not disputed
24 within a reasonable time;

- 1 (3) With each claim payment, the insurer shall provide to the insured an explanation of
2 benefits that shall include the name of the provider or services covered, dates of
3 service, and a reasonable explanation of the computation of benefits;
- 4 (4) No insurer may impose a penalty upon any insured for noncompliance with insurer
5 requirements for precertification unless such penalty is specifically and clearly set
6 forth in the policy;
- 7 (5) No insurer may deny a claim upon information obtained in a telephone conversation
8 or personal interview with any source unless the telephone conversation or personal
9 interview is documented in the claim file;
- 10 (6) Each insurer offering cash settlements of first party long-term disability income
11 claims, except in cases where there is a bona fide dispute as to the coverage for, or
12 amount of, the disability, shall develop a present value calculation of future benefits
13 (with probability corrections for mortality and morbidity) utilizing contingencies
14 such as mortality, morbidity, and interest rate assumptions, or other contingencies as
15 appropriate to the risk. A copy of the amount so calculated shall be given to the
16 insured and signed by the insured at the time a settlement is entered into;
- 17 (7) No insurer may indicate to a first party claimant on a payment draft, check, or in any
18 accompanying letter that the payment is final, or a release of any claim, unless the
19 policy limit has been paid, or there has been a compromise settlement agreed to by
20 the first party claimant and the insurer as to coverage and amount payable under the
21 policy;
- 22 (8) No insurer may withhold any portion of any benefit payable as a result of a claim on
23 the basis that the sum withheld is an adjustment or correction for an overpayment
24 made on a prior claim arising under the same policy unless:

- 1 (a) The insurer has in the insurer's files clear, documented evidence of an
- 2 overpayment and written authorization from the insured permitting the
- 3 withholding procedure; or
- 4 (b) The insurer has in the insurer's files clear, documented evidence that:
 - 5 (i) The overpayment was clearly erroneous under the provisions of the
 - 6 policy and that the overpayment is not the subject of a reasonable
 - 7 dispute as to facts;
 - 8 (ii) The error that resulted in the payment is not a mistake of law;
 - 9 (iii) The insurer has notified the insured within six months of the date of the
 - 10 error, except that in instances of error prompted by representations or
 - 11 nondisclosures of claimants or third parties, the insurer notified the
 - 12 insured within fifteen days after the date the evidence of discovery of
 - 13 such error is included in its file. For the purpose of this section, the date
 - 14 of the error shall be the day on which the draft for benefits is issued;
 - 15 and
 - 16 (iv) The notice stated clearly the nature of the error and the amount of the
 - 17 overpayment.

18 Section 11. Each life insurer, upon receiving due notification of a claim shall, within fifteen

19 days of the notification, provide necessary claim forms, instructions, and reasonable assistance

20 so the insured can properly comply with the insurer's requirements for filing a claim. The failure

21 to comply with this section is an unfair claims practice.

22 Section 12. No insurer may fail to settle first party claims on the basis that responsibility for

23 payment should be assumed by others except as may otherwise be provided by policy

24 provisions. This section applies only to life insurance and property and casualty insurance

1 coverage.

2 Section 13. If the insurance policy provides for the adjustment and settlement of first party
3 losses based on replacement cost, the following apply:

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

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

12 This section applies only to property and casualty insurance coverage.

13 Section 14. Sections 15 to 22, inclusive, of this Act, apply only to vehicle insurance
14 coverage as defined in § 58-9-11.

15 Section 15. If liability and damages are reasonably clear, no insurer may recommend that
16 a third party claimant make claim under the claimant's own policies solely to avoid paying any
17 claim under the insurer's policy.

18 Section 16. Any insurer shall, upon the claimant's request, include the first party claimant's
19 deductible, if any, in subrogation demands. Any subrogation recovery shall be shared on a
20 proportionate basis with the first party claimant, unless the deductible amount has been
21 otherwise recovered. No deduction for expenses may be made from the deductible recovery
22 unless an outside attorney is retained to collect the recovery. The deduction may then be for only
23 a pro rata share of the allocated loss adjustment expense.

24 Section 17. If any partial loss is settled on the basis of a written estimate prepared by or for

1 the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement
2 is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with
3 applicable policy provisions, and of an amount which will allow for repairs to be made in a
4 workmanlike manner.

5 If the insured subsequently claims, based upon the written estimate which the insured
6 obtained, that necessary repairs will exceed the written estimate prepared by or for the insurer,
7 the insurer shall:

8 (1) Pay the difference between the written estimate and a higher estimate obtained by the
9 insured; or

10 (2) Promptly provide the insured with the name of at least one repair shop that will make
11 the repairs for the amount of the written estimate. If the insurer designates only one
12 or two repairers, the insurer shall assure that the repairs are performed in a
13 workmanlike manner. The insurer shall maintain documentation of all such
14 communications.

15 Section 18. If the amount claimed is reduced because of betterment or depreciation, all
16 information for the reduction shall be contained in the claim file. Any deduction shall be
17 itemized and specified as to dollar amount and shall be appropriate for the amount of
18 deductions.

19 Section 19. An insurer shall provide reasonable notice to an insured prior to termination of
20 payment for vehicle storage charges and documentation of the denial as defined by subdivision
21 (7) of section 1 of this Act. The insurer shall provide reasonable time for the insured to remove
22 the vehicle from storage prior to the termination of payment. Unless the insurer has provided
23 an insured with the name of a specific towing company prior to the insured's use of another
24 towing company, the insurer shall pay any and all reasonable towing charges irrespective of the

1 towing company used by the insured.

2 Section 20. A betterment deduction may be allowed only if the deduction:

3 (1) Reflects a measurable decrease in market value attributable to the poorer condition
4 of, or prior damage to, the vehicle; and

5 (2) Reflects the general overall condition of the vehicle, considering its age, for either
6 or both of the following:

7 (a) The wear and tear or rust, limited to no more than a deduction of two thousand
8 dollars; and

9 (b) Missing parts, limited to no more of a deduction than the replacement costs of
10 the part or parts.

11 Any deduction pursuant to this section shall be measurable, itemized, specified as to dollar
12 amount, and documented in the claim file. No insurer may require the insured or claimant to
13 supply parts for replacement.

14 Section 21. Any replacement crash part, which is subject to this section and manufactured
15 after July 1, 2014, shall carry sufficient permanent non-removable identification so as to identify
16 the part's manufacturer. The identification shall be accessible to the extent possible after
17 installation.

18 No insurer may require the use of any replacement crash part in the repair of a vehicle unless
19 the replacement crash part is at least equal in kind and quality to the original part in terms of fit,
20 quality, and performance. Any insurer specifying the use of replacement crash parts shall
21 consider the cost of any modifications that may become necessary when making the repair.

22 Section 22. An insurer shall affirm or deny liability on claims within a reasonable time and
23 shall tender payment within thirty days of affirmation of liability, if the amount of the claim is
24 determined and not in dispute. In claims where multiple coverages are involved, payments

1 which are not in dispute and where the payee is known should be tendered within thirty days if
2 the payment would terminate the insurer's known liability under that individual coverage.

3 Section 23. The director may promulgate rules, pursuant to chapter 1-26, to carry out the
4 purposes of this Act. In promulgating any rules the director shall consider the impact of the rule
5 on the cost and availability of insurance in this state and the degree of protection that the rule
6 will have for the insurance buying public in this state. The rules are limited to following areas:

- 7 (1) Definition of terms;
- 8 (2) Claims handling procedures;
- 9 (3) Timeliness;
- 10 (4) Appropriateness of repairs;
- 11 (5) Determining actual cash value;
- 12 (6) Notice and communications to claimants;
- 13 (7) Valuation; and
- 14 (8) Record keeping.