

Property and Casualty  
Insurance (C) Committee  
Public Hearing on  
Catastrophe Issues

Washington, D.C.  
Sunday, December 2, 2012



# Agenda





2012 Fall National Meeting  
Washington, DC

**PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE**

Public Hearing on Catastrophe Issues

Sunday, December 2, 2012

8:00 – 10:00 a.m.

**ROLL CALL**

**Property and Casualty Insurance (C) Committee**

Mike Chaney, Chair	Mississippi		
Merle D. Scheiber, Vice Chair	South Dakota	James J. Donelon	Louisiana
Jim L. Ridling	Alabama	Eric A. Cioppa	Maine
Jay Bradford	Arkansas	Joseph G. Murphy	Massachusetts
Kevin M. McCarty	Florida	John G. Franchini	New Mexico
Gordon I. Ito	Hawaii	Eleanor Kitzman	Texas
William W. Deal	Idaho	Mike Kreidler	Washington

**AGENDA**

- 1. Opening Remarks and Welcome**— *Commissioner Mike Chaney (MS)* 5 Minutes
- 2. Consumer Perspectives**—*Amy Bach (United Policyholders), Birny Birnbaum (Center for Economic Justice) and J. Robert Hunter (Consumer Federation of America)* 30 Minutes
- 3. California Earthquake Authority Perspectives**—*Bruce Patton (California Earthquake Authority) and Glen Pomeroy (California Earthquake Authority)* 20 Minutes
- 4. Public Adjuster Perspectives**—*Ronald Papa (National Association of Public Insurance Adjusters)* 10 Minutes
- 5. Consumer Perspectives**— *Robin Smith Westcott (Florida Insurance Consumer Advocate)* 10 Minutes
- 6. Regulatory Perspectives**—*Joel Laucher (California Department of Insurance) and Dana Stein (Maryland House of Delegates)* 20 Minutes
- 7. Insurer Perspectives**— *Jim Whittle (American Insurance Association) and Paul Tetrault (National Association of Mutual Insurance Companies)* 20 Minutes
- 8. Concluding Remarks**— *Commissioner Mike Chaney (MS)* 5 Minutes

**Written testimony submitted by presenters and other interested parties will be posted to the NAIC website  
Monday, Dec. 3, 2012.**



# Consumer Perspectives





Testimony of Amy Bach, Executive Director, United Policyholders, NAIC Consumer Representative

Public Hearing on Catastrophe Claims, NAIC Fall National Meeting, Washington D.C.  
Sunday December 2, 2012

- 1) UP recovery survey results document catastrophe claim handling deficiencies/problems. (See attachment)
- 2) States are implementing reforms via legislation, regulation, bulletins and negotiations with industry.
- 3) Some carriers are using best practices and flexibility during the claim process. (E.G. CEA, State Farm waiver of inventory itemization requirement)
- 4) “Normal” cat claim problems related to adjuster/training/deployment limitations, the availability of reputable contractors, price-gouging/demand surge increases are being aggravated by:
  - The trend away from all-risk to named peril policies with an ever-growing list of exclusions
  - Over-reliance and improper use of Xactimate repair cost estimating software
  - Improper use of the appraisal process
  - The (un)professional “circus” that comes to town after disasters
- 5) Reforms should include:
  - a) Requiring that policyholder gets a complete, current copy of their policy as soon as possible after a loss and before any claim settlement offer is tendered.
  - b) Giving policyholders the right to review all non-privileged copies of documents in their claims file
  - c) Requiring carriers that rotate more than 3 adjusters in 3 months on a claim to give the policyholder written status reports
  - d) Reforms that carriers have voluntarily agreed to, including:
    - Relaxing contents inventory itemization requirements
    - Advancing ALE, Dwelling and Contents payments to aid in recovery
  - e) Reforms already implemented in Maryland, California, and elsewhere that include:
    - Min. 24 months of ALE
    - Min. 24 months to replace to collect full replacement value
    - Make appraisal informal and offer mediation options
    - Limit depreciation holdbacks under replacement cost policies



## Roadmap to Recovery Survey Results

### **2011 Central Texas Wildfires, Bastrop County**

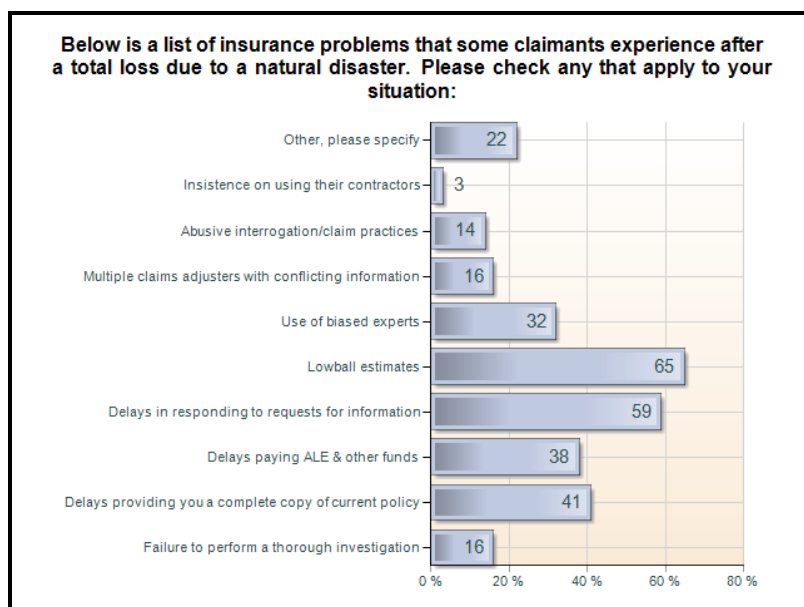
#### ***12 Month Survey Results - Our key findings include:***

- 56% of respondents reported being underinsured on their dwelling by an average of over \$110,000.
- 80% of respondents reported they do not have enough insurance money to replace their belongings. The average amount they fell short was \$97,000.
- 1/3 of respondents reported that their insurance company did not explain "depreciation" and how to collect full replacement cost on their items.

### **2010 Fourmile Canyon Wildfire, Boulder, Colorado**

#### ***12 Month Survey Results - Our key findings include:***

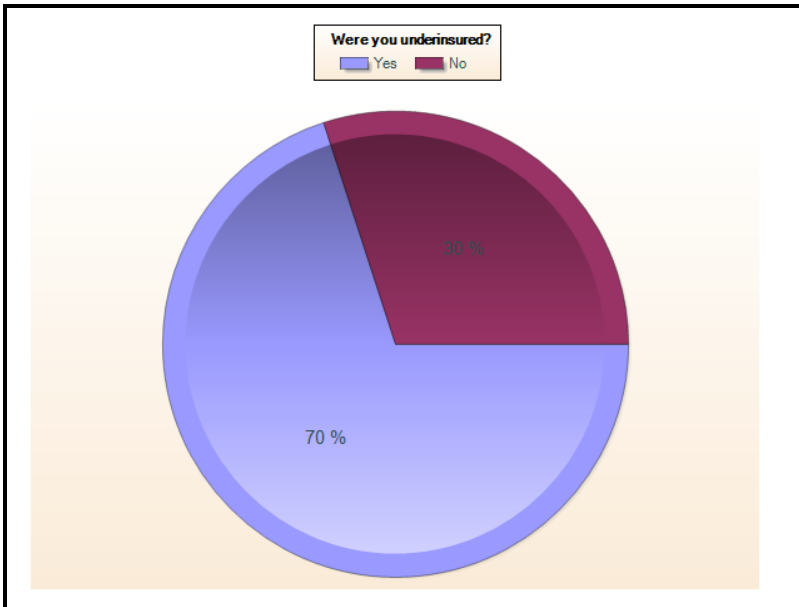
- 64% of respondents reported being underinsured on their dwelling by an average of over \$200,000.
- 36% of respondents have not yet reached a settlement with their insurance company on the dwelling portion of their claim.
- 65 % of respondents reported they received lowball estimates from their insurance company.
- 43% of respondents do not believe a fair value was placed on their possessions.
- 35% of respondents will run out of "Additional Living Expense" benefits before they rebuild/replace their home.



## 2007 Southern California Wildfires, San Diego County

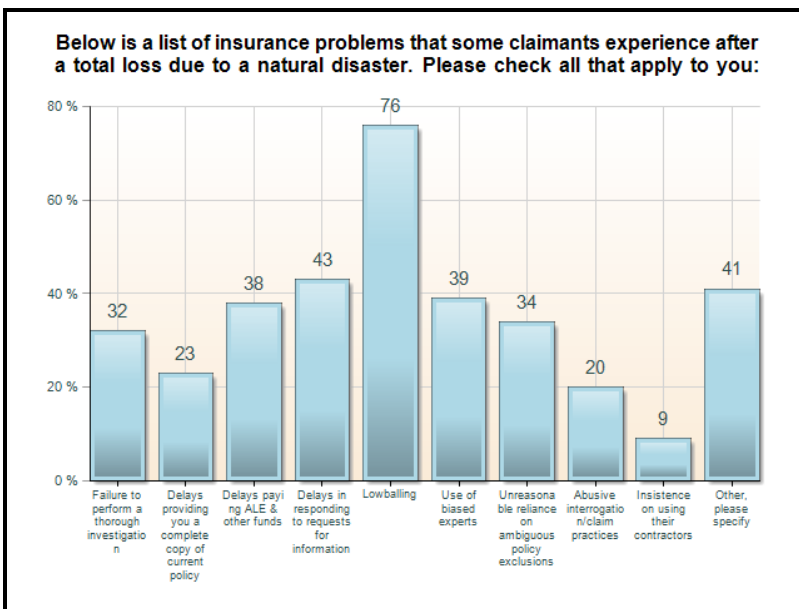
### 12 Month Survey Results - Our key findings include:

- 54% of survivors surveyed still had not settled the dwelling portion of their insurance claim.
- 70% of all respondents reported they were underinsured by an average of over \$250,000.



### 24 Month Survey Results - Our key findings include:

- 76% of respondents experienced "lowballing".
- 43% of respondents experienced delays in responding to requests for information.
- 39% of respondents experienced use of bias experts.



To view additional survey data, results and charts, visit [www.uphelp.org/surveyresults](http://www.uphelp.org/surveyresults)







# Consumer Federation of America

## NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS PROPERTY/CASUALTY INSURANCE (C) COMMITTEE PUBLIC HEARING ON CATASTROPHE ISSUES

By **J. Robert Hunter<sup>1</sup>**,  
**Director of Insurance**

December 2, 2012

### **Background**

The Committee has asked for comments on how to make post-disaster claims more consumer-friendly. These remarks are based on experience with consumers in disaster situations, including emerging issues causing consumer anguish in the Sandy aftermath. Both short-term and longer-term reforms are necessary.

### **SHORT TERM REFORMS**

#### **(A) Identifying the major insurance problem: Claims/Coverage Gaps leading to consumer troubles after the storm – Short-Term Solutions**

One of the key reasons post-catastrophe claims are painful to consumers is the fact that the homeowners insurance policy is packed with loopholes and caps and limits that most consumers do not understand. Most of the problems facing consumers are relatively new changes to the homeowners insurance policy. In recent years, insurers have succeeded in shifting significantly more of the risk of losses associated with extreme risks to policyholders. This has resulted in a significant and unacceptable risk exposure for most consumers who believe they are fully insured against all forms of loss and has also increased taxpayer exposure. The data showing how insurers have shifted risk and costs associated with weather catastrophes to consumers and the state and federal governments, is detailed in CFA's February 2012 report, "[The Insurance Industries Incredible Disappearing Weather Catastrophe Risk<sup>2</sup>](#)."

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<sup>1</sup> Mr. Hunter formerly served as Federal Insurance Administrator under Presidents Ford and Carter (during which time he ran the National Flood Insurance Program and administered the federal rules related to FAIR Plans) and as Texas Insurance Commissioner. In preparing this paper, Mr. Hunter had excellent input from Amy Bach, Executive Director of Policyholders United and Birny Birnbaum, Executive Director of the Center for Economic Justice for which he is very grateful.

<sup>2</sup> J. Robert Hunter, February 2012.

<<http://www.consumerfed.org/pdfs/InsuranceRegulationHurricaneRiskDisappearingCoverageStudy2-12.pdf>>

From the consumer perspective, it is helpful to look at claims/coverage issues in recent catastrophic events to determine what problems consumers face in the insurance market and what might be done to ensure that consumers have better access to homeowners insurance that meet their needs during catastrophic events. CFA has identified several issues that are important<sup>3</sup>:

**Consumers do not have sufficient flood insurance in force.** This was obvious even in Katrina, which hit an area of the country where NFIP's market penetration was relatively high, about 50 percent. In the Sandy impacted area, it is expected that about 70 percent of Sandy-flood-damaged homes do not have flood insurance.

**The conditions under which hurricane deductibles apply are unclear and result in consumer confusion.** Consumers do not understand when and if a hurricane deductible kicks in and when and if a wind deductible applies since the consumers had no say in the selection of these deductibles. It is also unclear to consumers whether it is the insurance company or a state regulatory agency that makes the determination that a severe weather event triggers these deductibles. It is unclear whether hurricane deductibles apply to claims in an entire state if a storm is classified as a hurricane in one part of a state but not in another part of a state. It is also unclear if the wind speed deductible is applied based on wind speed in the specific town or county or whether a trigger applies the deductible statewide.

**State prohibitions on hurricane deductibles may or may not apply to deductibles based on wind speed.** If a hurricane deductible is banned, as it has been in Sandy in New York, it is unclear whether that prohibition applies to wind speed deductibles not mentioning "hurricane." This is a relatively new problem, with many of these percentages, storm-related deductible clauses added to policies only since Hurricane Andrew in 1992.

**Consumers are extremely unaware of the anti-concurrent-causation (ACC) clause in their policies.** CFA recently released [information](#)<sup>4</sup> regarding this little known provision, which states that, if a structure is damaged at about the same time by two risks, one of which is covered (like fire or wind) and the other not (like flood), then either no coverage or limited coverage will be provided for the "covered" part of the claim. People do not believe that their own insurance company would design a trap door in the back of their policy through which the coverage they purchased can fall. This is a very new problem, emerging in the aftermath of Hurricane Katrina in 2005. The dense legalese in anti-concurrent causation exclusions confounded esteemed Federal and State judges after Katrina. They defeat consumers' reasonable expectations of coverage and should be banned.

**Consumers are often unaware that a cap on replacement costs may result in significant out-of-pocket costs.** Many consumers are not aware that caps on replacement costs are part of their homeowners insurance policy. Almost none are aware of the risk they take if a

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<sup>3</sup> California earthquake insurance policies face serious problems that are not covered in these comments.

<sup>4</sup> "Will Breezy Point's Firefighters Who Lost Their Homes to Fire During Superstorm Sandy Have Their Fire Insurance Claims Denied?" <<http://www.consumerfed.org/news/613>> November, 19, 2012.

catastrophic event occurs. After a severe weather event, the price of materials and labor to repair homes often increase considerably, a phenomenon known as “demand surge.” The replacement cap limits coverage to the amount stated in the policy as the replacement cost. Some insurers offer additional coverage of approximately 20 percent. Previously insurance policies guaranteed that repairs would be made even if the claims estimate were lower than the actual cost to make necessary repairs. However, replacement caps became common practice in policies written after Hurricane Andrew. If rebuilding prices surge, as is typical after a large event with many damaged homes, homeowners face significant out-of-pocket expenses. For example, if a family buys replacement coverage with a \$500 deductible on \$200,000 home and files a normal total loss fire claim, they will receive a claims check for \$199,500. If the damage to their home is the result of a hurricane, and building material scarcity results in a 50 percent price increase in building costs, that family would now need \$300,000 to restore their home. If the insurer imposes the replacement cost limit, and they receive a claims check for \$199,500, they will be far short of what they would need to be made whole. To rub salt in the wound, if they lived on the beach and the hurricane deductible of 5 percent of value is applied (in this case \$10,000) they would only receive a claims check for only \$190,000.

**Consumers are unaware that their policy probably does not cover the cost of mold removal.** Mold, which frequently follows water damage, is now excluded from most homeowners insurance policies. These exclusions were introduced in the last 10 years. In addition to adding mold exclusions, insurers have been consistently adding language that limits water damage from various sources, (such as sewer backup, off premises pipe damage, and damage resulting therefrom).

**Consumers are unaware that many policies do not cover additional costs if construction ordinances or building codes require certain upgrades.** For instance, if a structure is 50 percent damaged, flood insurance rules require elevation of the first floor of the whole home to the 100-year flood elevation, often a very expensive additional cost to rebuild a home. This is a relatively new problem since it was once part of homeowners insurance coverage. This exclusion was added to home insurance policies after Hurricane Andrew in 1992.

## **(B) Claims/Coverage –Short-Term Solutions**

### **Rewrite the Homeowners Insurance Policy to make it Fairer to Consumers When Future Storms Hit**

Today, homeowners’ insurance policies are like Swiss cheese rubbed with Limburger: stinky with lots of holes. Here are some suggestions for the State of New York to consider for address the claims/coverage issues identified above:

**Flood insurance should be offered in high-risk flood areas through private insurers<sup>5</sup>.** There are reasonably priced, private-sector service providers who can make the flood insurance rate map determination of risk that could be used to trigger the offer of flood

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<sup>5</sup> This proposal is an interim proposal to be in place until the long-term reform we propose in section C, below, is implemented.

insurance when a homeowners insurance policy is sold (they do it today for banks). If a home is in a high-risk flood area, the insurer should be required to offer flood insurance when selling any homeowners insurance policy. If a homeowner wants the flood coverage and the insurance company is an NFIP Write Your Own (WYO) insurer, the company can simply add flood insurance to the homeowner's insurance policy. If the insurer is not a WYO insurer, the home insurance carrier for the consumer can secure the flood policy from the NFIP direct servicing contractor and added to the policy package.

**States should require that a consumer choose the deductibles based on wind speed.**

NAIC's modernization of the homeowners insurance policy should remove the current, confusing hurricane-related deductibles and only allow wind speed deductibles to be used in the state. To attach the wind deductible, the insurer would be required to give, when the policy is sold, the policyholder an option to select the wind speed deductible from a table of different prices for different wind speed deductibles. The table should include a no wind speed deductible option. This consumer selection would be made at the time a policy is offered and the consumer would therefore know exactly what to expect if a storm hits.

**States should not allow anti-concurrent-causation clauses.** The ACC clause was intended to limit or even remove the insurer's liability when a covered risk damages a structure at about the same time as an excluded risk, regardless of the order of such events. After Hurricane Katrina, courts were asked to determine whether the insurance companies' language supersedes the common law doctrine of proximate cause. While many of the courts ruled that insurance companies could, in fact, use ACC clauses to avoid the common law rule of proximate cause, others found the clause too ambiguous and, ruled against the insurance companies. This draconian clause, hidden in the fine-print of the homeowners insurance policy, acts like a trap door that snaps open to the surprise of consumers, as the coverage consumers thought that they had falls through. The ACC clause should be prohibited from use for homeowners insurance policies.

**Caps on replacement cost (RC):** CFA proposes that the states require insurers to offer different RC caps at the time of sale with the price impact of each option being disclosed clearly to the consumer. Secondly, in a demand surge situation, insurers should be the risk-takers, not the policyholders. States should regulate claims practices to remove demand surge price changes from any calculation of the RC cap in a claim in a disaster situation. Recognizing that current policies are overly restrictive with regard to replacement cost coverage, [Maryland recently amended its laws](#)<sup>6</sup> to give disaster victims at least 24 months to collect full replacement cost.

**Mold exclusion:** CFA believes that states should require that mold coverage be a yes/no choice at the time of the policy sale with the cost implications fully disclosed to consumers.

**Law and Ordinance Coverage:** CFA proposes that states require, at time of sale, a yes/no decision on such coverage be offered to the consumer, along with the premium implications disclosed clearly.

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<sup>6</sup> 2010 Maryland Insurance Code, § 19-213 < <http://law.justia.com/codes/maryland/2010/insurance/title-19/subtitle-2/19-213/>>.

## 1) Catastrophe Claim Reforms

### Claims transparency

Consumers should be entitled to a complete copy of all documents in their claim file. Consumers should be informed they have a right to hire their own public adjuster but that they should be warned to check references, license status and experience before doing so. In cases of a declared natural disaster, appraisals should be optional, not mandatory. Information on when to consider the need to hire an attorney should also be included. Some of this material could be included in the homeowners insurance Bill of Rights proposed below. The California Insurance Code at sections 2071, and [2051.5](#) provide a reference point for suitable language.

### Claims adjuster licensing and accountability

The NAIC should propose a system of national licensing of claims adjusters for catastrophe situations and establish minimum standards for training and competency among adjusters. There is a wide range of skill/training and competencies among insurance adjusters. In some cases, financial incentives for independent adjusters cause them to skimp on the quality of loss assessments and move on to the next assessment in order to maximize income. These incentives result in some adjusters underestimating repair estimates and also cause delays.

The contracts that the large independents like Crawford & Co., General Adjustment Bureau and others have in place with the major property/casualty Insurers are enormous. These independents are provided with the claims handling guidelines of the Insurers they have contracted with and are expected (contractually) to adhere to those guidelines. There may also be financial incentives or disincentives written in the contracts between the Independent firm and the insurer. The Insurer will also conduct a percentage of re-inspections, some on-site and some paper reviews to determine if the independent is adhering to the Insurers' claim handling guidelines and contractual obligations. Regulators should examine these contracts including the SOW (statement of work), which is the section of the contract that outlines the specific expectations, incentives and penalties to determine if policyholders are at risk of being shortchanged.

### Data Needs

To the extent not done today, NAIC should initiate a process to collect Sandy claim data that will include:

- Homeowner claims filed, amounts paid, amounts denied, cause of loss, value of structure in policy, value of structure determined at the time of the claim, was the anti-concurrent-causation provision applied, law and ordinance claims denied and how deductibles were applied.
- NFIP claims paid, amounts denied, amounts paid should be obtained from FEMA.

- Commercial claims filed, amounts paid, amounts denied, cause of loss and how deductibles were applied.
- Cost data for remediation, restoration, and repairs/construction services post-Sandy.

**2) Require a Consumer Bill of Rights Accompany Every Homeowners Insurance Policy Sold and Every Claim File Opened in the State**

NAIC should establish an insurance policyholder’s bill of rights using the bill of rights adopted in Texas as a model. This bill of rights should be provided to policyholders at the time of sale of a policy as well as when a claim file is opened. The Bill of Rights should contain information on how to fairly settle claims in a disaster situation.

**3) NAIC should draft a model bill for the regulation of vendors whose products impact the catastrophe claims and pricing decisions of insurers**

States should be empowered to regulate vendors whose computerized products have serious impacts on claims settlement offers and on hurricane and other storm prices charged by insurers in the state. Products such as “Xactimate” impact the valuations of homes for claims payout purposes. Products like CAT models impact the price of insurance for homeowners. Yet these models and computerized ‘black boxes’ are essentially not regulated. Providers of such products should be regulated as advisory organizations in the same way that other entities, like the Insurance Services Office, are regulated.

**LONG-TERM REFORMS**

**The NAIC Take a Lead in finding a National Long-Term Solution to the Massive Underinsurance on the Coast and to Rationalizing our Topsy-Turvy National Catastrophe Insurance System**

**Minimizing Underinsurance for Coastal Hurricane Risk**

In recent years, insurers have succeeded in shifting significantly more of the risk of losses associated with extreme risks to policyholders and to government (State and Federal), while continuing to insure for their own accounts higher frequency, lower severity risks. This has resulted in a significant and unacceptable risk exposure for most consumers who believe they are fully insured against all forms of loss and has also increased taxpayer exposure.

The largest area of consumers' underinsurance for the flood peril is due to the fact that a separate policy purchase is required. We suggested a short-term fix for this above but a longer-term solution is outlined here.

Behavioral economics offers some insight on why people fail to purchase flood insurance: a general underestimation of risk and over-hyped expectations regarding federal bailouts in case of an event (e.g., many expect grants rather than loans). These behavioral trends suggest that the flood peril should be part of every basic homeowners policy. Our comments above lay out a number of other insurance issues about which consumers have limited knowledge or

understanding. As with the presence or absence of flood peril, anti concurrent causation, mold coverage, additional building costs, replacement cost out of pocket and other problems with the homeowners policy provide graphic evidence of the failure of the current insurance market model of consumer "choice" paired with "disclosures." The results of Sandy -- evidence of under-insurance, irrational insurance choices and surprise and misunderstanding of coverage purchased -- indicates that a new model of insurance markets is needed with regulators becoming far more pro-active in enforcing statutory requirements that policies not be misleading, confusing or deceptive.

The absence of flood insurance from the basic homeowners policy leads to massive inefficiencies in addition to massive under insurance. The inefficiencies arise from the second set of administrative costs associated with a flood policy that would not exist if flood were part of the basic homeowner policy and from the additional claim settlement costs associated with determining which policy (if any) covers the damage. GAO<sup>7</sup> estimates that the WYO companies take one-third to two-thirds of the premiums the NFIP collects just for overhead costs (and that excludes the federal direct costs).

The absence of flood coverage from the basic homeowners policy is inherently misleading and deceptive to consumers. It is unreasonable to expect a consumer to parse through which types of damage are or are not covered by a policy -- wind damage, water damage following wind damage, water damage caused by wind, storm surge, flooding, and so on.

The NAIC should propose a model bill to require flood insurance to be included as part of the basic homeowners policy to create a policy with coverage that consumers expect, to provide coverage for flood and water losses in the most efficient manner possible and to eliminate unreasonable claim settlement problems.

In addition to providing a product that meets the basic financial and economic security needs of consumers, broadening the risk pool for flood peril, eliminating inefficiencies in the provision of flood insurance and transforming an inherently deceptive product (homeowners) into a fair and reasonable product, requiring flood coverage as part of the homeowners policy will spur insurers to become more proactive on loss mitigation and loss prevention, which is the only long-term strategy for addressing growing natural catastrophe risk.

The transition to an "all-risks" homeowners policy should take place over two to five years and include the creation of a public option insurer with the ability to compete with the private market throughout the state if private insurers fail to offer the all risks policy in all parts of the state.

The basic insurance model -- a risk pool diversifying and spreading the risk of many consumers - - must give way to insurance as both risk transfer and a mechanism to finance and implement loss mitigation and loss prevention. Part of this is accurate pricing of the insurance -- this is essential to give consumers and businesses the appropriate price signals to make informed and rational decisions about their investments in property and structures. But the most important part of this is engaging insurers and the public sector to partner with policyholders to finance the

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<sup>7</sup> 'FEMA's Management and Oversight of Payments for Insurance Company Services Should be Improved,' GAO, Report 07-1078, September 2007.

essential investments in loss mitigation -- be that CAT-resistant-structures or other loss prevention measures.

The adoption of a rationalized all-risk homeowners' insurance policy could be part of a national discussion, initiated by the NAIC, to discuss and create a national program to provide coverage against all forms of risk, including flood and earthquake risk.

- 1. Consumers would bear the first layer of cost of losses, including catastrophic losses,** through reasonable deductibles and clear exclusions but would not face significant out-of-pocket costs due to a surge in building costs or denials of claims due to anti-concurrent-causation clauses or other such surprise provisions that devastate the unsuspecting policyholder.
- 2. The private direct insurance market would bear the responsibility of paying for claims above the policyholder retention** up to the total of all damage.
- 3. Private reinsurers (and ACT bond providers, etc.) would participate in funding these damage claims in accordance with an organized system of reinsurance** that included government participation only in the case of extreme events. The federal government would reinsure above that level, with state governments responsible for a percentage of the reinsurance cost the federal government paid out<sup>8</sup>.
- 4. Homeowners insurance premiums would be distributed to the private and public risk bearers in accordance with their actuarial risk.**
- 5. All parties would share in loss mitigation activity,** with the federal government continuing to analyze and produce risk maps and facilitate the development of serious building and land use codes. The federal government would also monitor code enforcement. In communities with weaker enforcement, a surcharge on the rates would be imposed.

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<sup>8</sup> It could work like the Riot Reinsurance Program the Federal Insurance administration ran in the 1970s. under which each state was to reimburse the Department of Housing and Urban Development for certain reinsured losses in a given contract year up to five percent of the aggregate property insurance premiums earned in a state when other stand-by resources were exhausted.



# California Earthquake Authority Perspectives





Property and Casualty Insurance Committee  
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December 2, 2012

1

## The CEA Today

- Voluntary for insurers – facilitates insurers' participation in California insurance market
- More than 830,000 policies in force – largest residential-earthquake-insurance provider in U.S.
- Writes 70% of all California residential earthquake insurance policies
- By law, CEA rates must be **actuarially sound**



2

# Publicly managed

## CEA Governing Board



- Voting member
- Non-voting member



# Privately funded



# New Zealand Earthquake Commission



## Public Insurance Program

Basic Cover: \$100,000 through EQC

Top-up Cover: Private Insurance

Take-up rate: 98%

## Christchurch Earthquakes

September 4, 2010 7.1

February 22, 2011 6.3

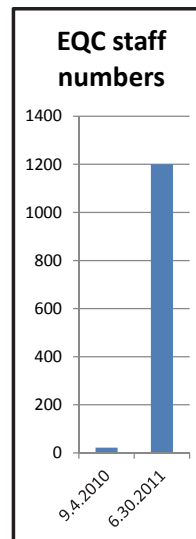
Source New Zealand Treasury

5

# Christchurch Earthquakes



9-4-2010	150,000 Claims
2-22-2011	156,000 Claims
<u>Other EQ</u>	<u>146,000 Claims</u>
<b>Total claims</b>	<b>452,000 Claims</b>



Source New Zealand Treasury

6

## Two Different Approaches to Claims Process

### CEA

- Participating Insurers (PI) adjusters handle claims for CEA
- PI pays insured, CEA reimburses PI
- If home can't be fixed pays policy limits
- No conflict with PI over who covers what

### New Zealand EQC

- Had to hire adjusters
- Hired contractors to fix damaged homes
- Fixing liquefied soil
- Conflict over shared coverage – PI and EQC

7

## Why the CEA Does Not Employ its Own Adjusters

- Participating Insurers' want to service their own policyholders
- PIs already have existing seasoned, tested, well managed catastrophe claim adjusting structures
- Due to the infrequency of earthquakes
  - The CEA couldn't recruit enough adjusters in time of need
  - The CEA can't keep necessary claim management on staff
  - Independent adjusters have other loyalties, Expensive

8

## Participating Insurers

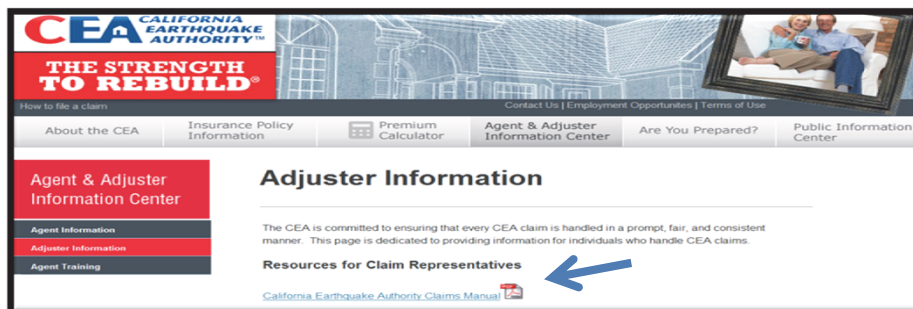
- Each Participating Insurers (PI) has a **CEA Claim Liaison** that reports to CEA
- Participating Insurers (PI) work under a very clear **PI Agreement** that is a contract for handling CEA claims.
  - SECTION 6.3 The Participating Insurer shall **handle all Authority Services with a level of diligence substantially equivalent to that which it applies to its own services** as a voluntary insurer...
  - SECTION 1.3. ... The Authority **shall not indemnify the Participating Insurer for any loss resulting from the failure** by the Participating Insurer, or its agents or employees, to comply with directives of the Authority or from violating statutory, regulatory, or common law governing claims handling practices.



9

## CEA Claim Manual

- The CEA has a comprehensive CEA Claim Manual that our PIs are required to follow.
- This manual can be retrieved from the CEA Web site at: [www.earthquakeauthority.com](http://www.earthquakeauthority.com).



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## CUREE Inspection Guidelines

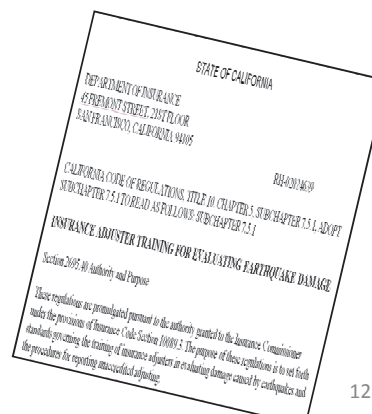
- The CEA requires PIs to be familiar with and use the *CUREE General Guidelines for the Assessment and Repair of Earthquake Damage in Residential Woodframe Buildings*.
- These Guidelines are a free download at [www.curee.org](http://www.curee.org) - Document EDA-2.
- Occupant questionnaire
- General inspection checklist
- Attic inspection checklist
- Crawlspace inspection checklist
- Funded by CEA but independently created and peer reviewed.



11

## California EQ Adjuster Training Regs.

- The **California Department of insurance** has established regulations that set forth standards governing the training of insurance adjusters in evaluating damage caused by earthquakes. This applies to CEA and non-CEA earthquake claim handlers.
- All CEA Participating Insurance Company claim handlers and claim management are required to attend training that meets these CDI standards once every three years.



12



## Annual CEA Claim Liaison Training

- CEA Claim Liaisons **must attend** the annual full-day CEA claims manager conference where duties and claim handling expectations are communicated and reinforced.
- These conferences are attended by all the CEA Claim Liaisons as well as their CEA claim management team.
- Typical attendance is around 100.



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## CEA Provides Ongoing Training on CEA Coverage and Claim Handling Expectations

- **On-line 24 / 7**
  - On-line CEA coverage training with test
  - On-line CEA deductible calculator
  - PDF copies of all CEA policies
  - CEA Claim Manual
- **In-person**
  - Trains independent adjusters
  - Trains PI managers and adjusters
  - CPCU Annual Conference
  - PLRB Annual Conference
  - CCNC Annual Conference
  - CAIIA Regional meetings

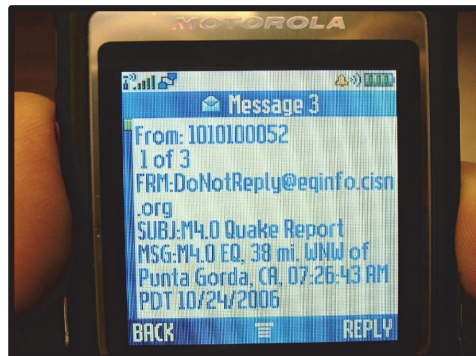


[www.earthquakeauthority.com](http://www.earthquakeauthority.com)



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## When an Earthquake Occurs...

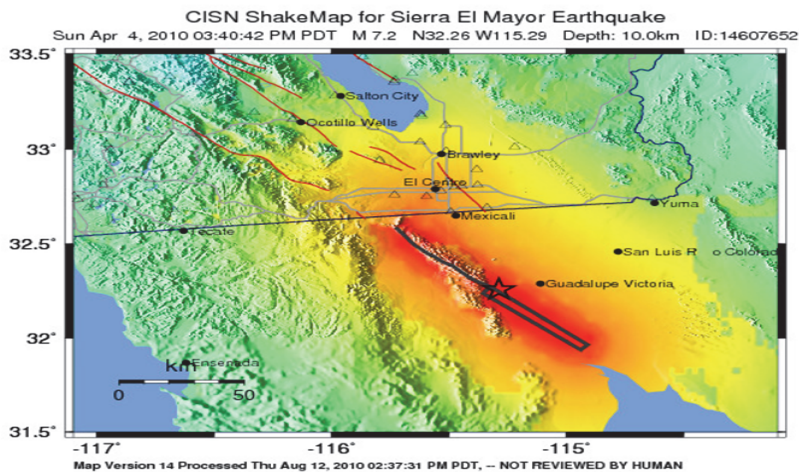


CEA executives receive notification via cell phone



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## CEA Immediately reviews USGS ShakeMap

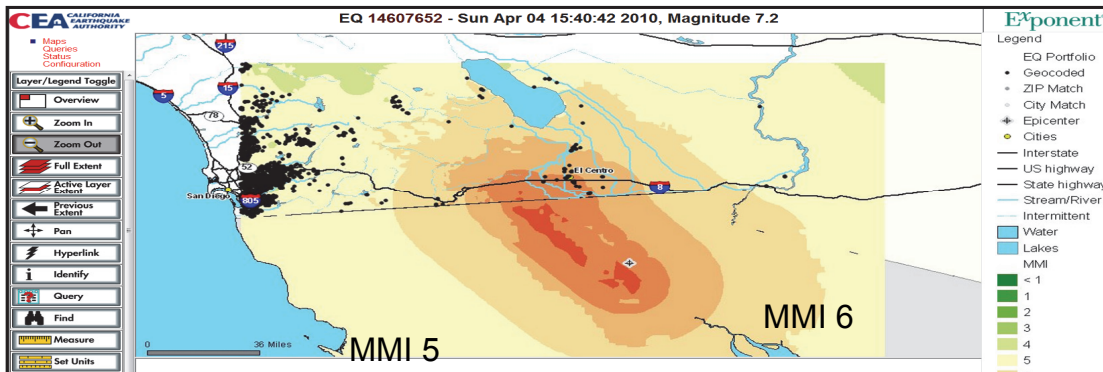


PERCEIVED SHAKING	Not felt	Weak	Light	Moderate	Strong	Very strong	Severe	Violent	Extreme
POTENTIAL DAMAGE	none	none	none	Very light	Light	Moderate	Moderate/Heavy	Heavy	Very Heavy
PEAK ACC.(mg)	<.17	.17-1.4	1.4-3.9	3.9-9.2	9.2-18	18-34	34-65	65-124	>124
PEAK VEL.(cm/s)	<0.1	0.1-1.1	1.1-3.4	3.4-8.1	8.1-16	16-31	31-60	60-116	>116
INSTRUMENTAL INTENSITY	I	II-III	IV	V	VI	VII	VIII	IX	X+

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# GIS Analysis of Impacted Policyholders

The CEA runs an extract of all the affected policyholders so we can get an immediate sense of impact and start our media and claims management response.



CEA EARLE System – 24 / 7 Internet access

## Determine Potential Claim Volume for each Participating Insurance Company

The CEA runs an extract of all the affected policyholders by PI so CEA can monitor their claims response.

**CEA CALIFORNIA EARTHQUAKE AUTHORITY EARLE** **Earthquake Portfolio**

CEA home  
EARLE home  
Maps  
Queries  
Field inspection data  
Status

Summary statistics of coverage and ground motion shown in the table below.  
Data selection criteria are:  
earthquake=14607652  
and portfolio=2010Q1  
and MMI>=5.5  
and company is any of 15598.

**AAA**

**Earthquake 14607652**

Portfolio 2010Q1  
11 total properties affected.

	Minimum	Mean	Maximum	Total
Cov. A	\$206,000.00	\$294,727	\$455,000	\$3,242,000
Cov. C	\$5,000.00	\$15,000	\$75,000	\$165,000
Cov. D	\$1,500.00	\$3,955	\$15,000	\$43,500
Cov. E	\$	\$	\$	\$
Cov. F	\$10,000.00	\$10,000	\$10,000	\$110,000
PGA	10.3174	23.00057	32.5993	NA
PGV	11.0736	22.31736	34.4263	NA
MMI	5.77	6.87636	7.68	NA
PSA03	21.5153	47.52470	72.5608	NA
PSA10	11.6142	21.91634	32.1613	NA
PSA30	6.1879	10.71671	16.0096	NA

NA: not applicable.



## Day 1 - CEA Claim Manager Goes Onsite

- The CEA Claim Manager will travel to the site of the earthquake and remain onsite as long as necessary
- PI catastrophe response offices are reviewed.
- Agent visits to take the temperature of the claim handling.
- Hold adjuster meetings and consult with PI's.



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## Controlling Claim Payments

- All requests for reimbursement of a payment by the PI go through a three-step validation and approval process.
  - **Step one:** The CEA system checks to make sure the payment fits within in-force policy provisions and coverage limits.
  - **Step two:** Payment is validated by claim manager.
  - **Step Three:** Payment is reviewed and approved by CEA Accounting.



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## Quality Control Claim Reinspections

- The CEA has a contract in place with a large independent adjusting company to conduct re-inspections of claims after an earthquake.
- The purpose of these claim reinspections is to ensure consistency of claim handling and proper scoping and estimating of damages.
- We statistically select claims to be reinspected from every company and in every size category.



## California Department of Insurance Earthquake Mediation Program



- The CEA uses the CDI EQ Mediation program to resolve disputes.
- This mediation program is administered by the CDI and costs the policyholder nothing.
- It has been used successfully in the past to settle claims with disparities in the listing and dollar amount of damage.





# Public Adjuster Perspectives





# NATIONAL ASSOCIATION OF PUBLIC INSURANCE ADJUSTERS



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TESTIMONY OF THE  
NATIONAL ASSOCIATION OF PUBLIC INSURANCE  
ADJUSTERS  
BEFORE THE NATIONAL ASSOCIATION OF  
INSURANCE COMMISSIONERS  
PUBLIC HEARING ON  
CATASTROPHE CLAIMS

NAIC FALL NATIONAL MEETING  
WASHINGTON, DC  
DECEMBER 2, 2012

TESTIMONY PRESENTED BY

RONALD J. PAPA, SPPA  
PAST PRESIDENT, NAPIA

PRESIDENT  
NATIONAL FIRE ADJUSTMENT CO., INC.



**TESTIMONY OF THE NATIONAL ASSOCIATION OF PUBLIC INSURANCE ADJUSTERS  
BEFORE THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS  
PROPERTY and CASUALTY INSURANCE (C) COMMITTEE  
PUBLIC HEARING ON CATASTROPHE CLAIMS**

**NAIC FALL NATIONAL MEETING  
WASHINGTON, DC  
DECEMBER 2, 2012**

Good morning commissioners, my name is Ronald J. Papa of Buffalo, New York, president of National Fire Adjustment Co., Inc., a fourth-generation family-owned-and-operated public insurance adjustment firm. I am also a past president of the National Association of Public Insurance Adjusters, the oldest professional association of public adjusters in the country. On behalf of NAPIA president Ron Reitz, the NAPIA officers, and the hundreds of public insurance adjusters that comprise the membership of the country's premiere public adjuster trade association I am pleased to offer testimony before this hearing today.

The good and the bad of the catastrophe claims process are currently on display in cities and towns throughout New York, New Jersey, Connecticut and other mid-Atlantic and northeast states. As residents and businesses impacted by Superstorm Sandy continue to recover from the enormous destruction of this event, many are learning for the first time the complexities—and vaguaries--of the insurance claims process. For some, the result of the claims process will be satisfactory; for others it will be wholly unsatisfying and may well prevent them from returning to a home or re-opening a business.

As with so many disasters, where goodwill initially seems to be in abundance only to find it in short supply just a few weeks into the recovery process, Sandy is now educating a whole new segment of the public to the complex and perhaps archaic way insurance is written and processed in the United States.

**TESTIMONY OF RONALD J. PAPA,  
NATIONAL ASSOCIATION OF PUBLIC  
INSURANCE ADJUSTERS**

The headlines tell a story all their own: from the New York Daily News: “Some insurance companies to Sandy victims: You are covered for hurricanes, not floods”; from the New York Post: “Homeowners face insurer sandbagging”; from WPIX-TV: “Long Island Homeowners Face Insurance Nightmare.”; from Reuters: “After Sandy damage, insurance adjusters may bring more bad news”; and, again from the New York Daily News: “Storm-savaged Brooklynites fighting with insurers and the feds.” On the ground there is a palpable sense of frustration and despair that the financial safety nets many thought were there are proving to be mere illusions.

This hearing and the concerns of the National Association of Insurance Commissioners over elements of the catastrophe claims process, predate Sandy’s arrival in late October; the foresight in calling this hearing is only punctuated by the enormous impact of this most recent storm. Instead, this hearing was conceived long before anyone knew of Sandy because of well-known challenges in the management of catastrophe claims in the past. NAPIA appreciates, first and foremost, the NAIC’s continuing focus upon these issues and the opportunity for NAPIA to join the public discussion on the nature of these problems and steps that can and should be taken to address them.

Sam Friedman, well known to us all as the former editor of the National Underwriter, recently wrote in that journal that a survey conducted for the national consulting firm Deloitte may have summed up the core issue concerning the catastrophe claims process (indeed, a claim for any type of loss) when he asked the following rather probing question based on comments received from survey participants:

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“If processing a claim is indeed the moment of truth in an insurer’s relationship with customers, why are small business consumers being kept in the dark when it comes to how a loss will be handled?”

For public insurance adjusters, public education on insurance coverages (the what’s in versus the what’s not in) and insurance claims processes (the what to do’s versus the what not to do’s), are central to any effort at improving the claims process. While this panel has asked for opinions on specific coverage issues, among other things, and which I will offer opinions in a few moments, this discussion must necessarily start with the issue of public education of the claims process.

Friedman continued:

“I found it somewhat alarming that so many of these small-business consumers were ignorant about how a claim is handled, particularly if the facts of the loss or coverage details are brought into question. It sounded to me as if insurers were asking for trouble—in the form of reputational damage, the loss of business and the threat of bad-faith litigation—as long as buyers are often clueless about their coverage and the claims-management process.”

This is a damning assessment of the industry, especially when placed in the context of Sandy. The issues arising with this storm have come to highlight, among other things, the rather dysfunctional vector point of private insurance and federal flood insurance, which is as smooth as a shard of glass. As spot-on as Friedman’s condemnation of the insurance industry’s efforts to keep many claimants in the dark about the realities of the claims process may be, it could be expanded upon even further when coupled with the significant misinformation—

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INSURANCE ADJUSTERS**

some at the hands of the insurers themselves and, regrettably, some within the regulatory community as well—purveyed about public insurance adjusters and their efforts to represent insureds in the claims process.

Public insurance adjusters—or PAs as they are better known—may be the single most important friend of the insured when it comes to navigating the claims process. Sandy is just the latest body of evidence supporting this notion. Many insureds rely upon those who sold them the insurance, brokers and agents, to help them navigate the claims process, as Friedman’s survey found. In many cases, these insurance professionals are excellent representatives for the consumer, but their expertise is mostly at the front-end of the process, namely the underwriting and securing of coverage. Others, especially captive agents who are employed by the carriers, will not be able to exercise the requisite independence from their carrier employers when the push comes to the inevitable shove within the claims process. Public adjusters, rather, are truly independent representatives working solely on behalf of claimants, bringing significant insurance knowledge (buttressed, for NAPIA members, by mandatory continuing education through the same organization that also confers CPCU degrees, among other entities) to the claims process.

The key to the claims process is in understanding what the *insurance value proposition* cemented during the insurance procurement process means to a claimant. Insurers argue regularly, and incorrectly, that public insurance adjusters increase the cost of insurance by inflating the size of claims; PAs don’t look to get more than what the insurance policy provides, assuring delivery of all the benefits that a policy provides and promises as a result of that value proposition. There is oftentimes a wide delta between that factor and what an insurer is willing to offer on a claim.

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Public insurance adjusters are just like insurance agents and brokers, or independent adjusters who, somewhat incongruously to their professional title, represent the insurance company in almost all cases. In 45 states, public adjusters are licensed and regulated by state insurance departments. As small businesses themselves, public adjusters are also regulated by the marketplace, relying upon reputation for trustworthiness and effectiveness to remain in business. Further, as members of NAPIA, these elite public adjusters are held to the highest professional standards in a quasi-self regulatory organization setting.

NAPIA leadership and members from around the country have spent the past year traveling around the country meeting with insurance regulators from Florida, Kansas, New York, Colorado, Texas, Illinois and many other states to educate regulators as to the role of public adjusters and their important contribution to the claims process. Public insurance adjusters have been maligned by over-generalizations of the industry fueled by some bad actors in a way not done to insurance agents, carriers and other licensees, many of which also have their share of unscrupulous characters. Right now, claimants on the east coast are clamoring for the assistance of public adjusters and state insurance departments have been allowing emergency licensing and other catastrophe-limited exemptions from the usual rules in order to accelerate the number of public adjusters allowed to assist the millions of claimants coming out of Sandy. The regulator's understanding of the public adjuster's true value has improved significantly. Consequently, instances of public comments by regulators or their staffs misrepresenting what public adjusters do or how they operate have been on the decline and for that we are grateful.

Public adjusters and the regulatory community forged a strong working relationship during the crafting of the public adjuster licensing act in 2005. Brian

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Goodman, NAPIA's general counsel, spent much time with commissioners and staff to see the model act through to fruition. This model has served as the foundation for many, if not most, of the public adjuster licensing measures passed in numerous state legislatures since the model's acceptance by the NAIC as MDL-228.<sup>1</sup> Without doubt, the passage of the model act at the NAIC and in state houses across the country have vastly improved the professionalism of those licensed to practice this profession.

Since then, though, there has not been a continuous flow of communication between regulator and regulated, something NAPIA is now looking to rectify and for which it takes full responsibility. Better exchanges of ideas and intelligence on public adjuster fees, public adjuster assistance on disaster data gathering, self-surveillance of public adjuster activities by the industry, and of course on the most challenging problem for both the public adjuster community and the regulatory community—the unauthorized practice of public adjusting, or UPPA, by those not licensed—are not merely on the horizon; they are here.

The unauthorized practice of public adjusting continues to serve as a parasitic force within the industry, preying upon an unwitting consumer population by offering deals that are simply too good to be true. Unlicensed contractors, roofers, lawyers and others who hold themselves out as licensed public adjusters or who circumvent state law by lurking in the shadows, feeding on the commotion of a disaster and offering to serve the public in settling claims with insurers without even pretending to be authorized to do so, are as much a

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<sup>1</sup> Twelve states have adopted some version of MDL-228: Idaho, Illinois, Iowa, Kentucky, Louisiana, Mississippi, New Hampshire, North Carolina, Pennsylvania, South Carolina, Virginia and West Virginia. It should also be noted that Model Act-derived bills are under active consideration in Alabama, Georgia and Wisconsin.



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scourge to the legitimate public insurance adjuster community as they are to regulators, law enforcement and emergency management professionals.

Those engaged in UPPA are out there deliberately trying to harm the public through their own special brand of fraud. Worse still, they also will prevent insureds from gaining the kind of information that is often critical to the wholesale recovery from a disaster, far beyond just insurance claim proceeds. The professional, licensed public insurance adjuster is knowledgeable about FEMA and NFIP interfaces with private coverage, Small Business Administration loans and other elements of the economic safety net which may be as crucial—if not more so, in situations such as Sandy which will prove to be much more of a flooding event than a wind or fire event—as any insurance recoverable which may be available.

A critical element missing in the war on UPPA is the insurer's direct engagement on it. Insurers—many at least—are well known for loathing the engagement of a public insurance adjuster on a claim and go out of their way in many instances to discourage a claimant from doing so. The transparency that Mr. Friedman calls for in his piece (“Insurers also have an obligation, I would think, to not only clearly communicate their coverage up front in terms most small business consumers could understand but to make the claims-management process more transparent and user-friendly as well.”) must include the sharing of information by insurers and others on the value that a public insurance adjuster may provide to the claims process. Further, in addition to offering transparency, the insurers must be vigilant not to wittingly or unwittingly work with those they know are improperly holding themselves out as licensed or otherwise authorized representatives of their insureds. They may be the only party “in the know” who can call out

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someone engaged in UPPA; it should be part of their obligation as licensees of the state to do so.<sup>2</sup>

An aggressive crack down on UPPA is needed and needed now if the consumer is to be protected, especially in times of catastrophes. Texas and Arizona, for example, recently issued bulletins warning against adjusting claims without a license. In June of this year, Commissioner Eleanor Kitzman from Texas noted

It has come to the attention of the Texas Department of Insurance that a number of contractors, roofing companies, and other individuals and entities not licensed by the department have been advertising or performing acts that would require them to hold a public insurance adjuster license. Additionally, the department has learned that the tactics used by these unlicensed individuals include visiting neighborhoods and areas of the state where languages other than English are commonly spoken. These unlicensed individuals often prey on unknowing consumers by promising to 'work' insurance claims to achieve a higher settlement.<sup>3</sup>

Arizona's concerns focused specifically on catastrophe scenarios and the proliferation of UPPA:

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<sup>2</sup> What could the insurance industry's response possibly be when approached by someone such as the contractor whose advertisement is attached here as Exhibit A? Is it the clear conflict of interest that the insurer will ignore, is it the "too good to be true" bargain that the contractor is offering the claimant that the carrier will try to take advantage of by cutting a deal with this contractor? Or, is it the numerous misspellings that will raise a red flag among an experienced claims handler?

<sup>3</sup> NAPIA also applauds Commissioner Kitzman for establishing an advisory group inclusive of public insurance adjusters, lending an important voice in the regulatory discussions on how best to serve, and protect, the public.

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Over the past fifteen years, there has been a growing trend where out-of-state and specialty restoration contractors come to catastrophe areas. Some have one or two page contracts that essentially give them the right to act as the contractor and adjust losses for policyholders, as the contracts require payment based upon the insurance recovery. The Arizona Department of Insurance noted this trend, that it is illegal and the possibility of exploitation [is high].

NAPIA stands ready to work with the NAIC and insurers to make certain that only qualified and licensed public insurance adjusters are representing insurance consumers.<sup>4</sup>

As noted earlier, so much of what goes on in the claims process is reflective of the comprehensiveness of the underwriting process. Public insurance adjusters, in their practices, are oftentimes asked to rewrite a script that may be months or years old, and a script of a conversation of which they were not a part. The discussions at the front end of the insurance process—agents understanding what clients need, communicating with markets to get coverages that best fit those needs, explaining to insureds how bound coverages fit or diverge from those identified needs, and the consumer understanding what they have or don't have by way of coverages. It is axiomatic that some policies are re-underwritten in the claims process, many times for the benefit of the insurers and sometimes for the benefit of the claimant, but by and large the issues in the claims process—aside

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<sup>4</sup> A number of other states have put out regulatory pronouncements on UPPA and those measures are appreciated by NAPIA and its members. Iowa, Minnesota, North Carolina, Ohio, and Oklahoma, among others, have issued directives forbidding the unauthorized practice of public adjusting, stating that only public adjusters are licensed to work for insureds on first-party claims matters. As stated below, NAPIA strongly encourages all state regulators to issue written directives reminding parties of the need for licensure to handle these types of claims.

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from the shortcomings within the claims process itself—come from shortcomings in the underwriting process.

Some of the issues on the front end are by design; as some of your questions infer, there may not be sufficient transparency as to how coverages relate to risks, and how premiums relate to coverages. Many consumers believe *having insurance* equates to *having insurance for everything* and that is the way some in the industry seem to like it. We all know that is not accurate, however, and it is a real kick in the teeth, as they say, to only find that out after a claim. Some agents never take the time to explain these critical issues because the economics of the modern insurance agency may not allow the time to do so, and many insureds simply don't take the time to understand them when the erstwhile agent tries to do so.

Also, the way insurance is marketed these days, where on line applications and promises of binding coverage in less than 15 minutes bring visions of efficiency nirvana, is antithetical to consumers truly understanding what they are buying. Further, many insurers are simply not selling their own wares anymore; cross selling of auto by separate homeowners carriers, and vice versa, has led to many problems once claims develop.

Some of the issues on the front end reflect the realities of insurance: business owner policies *are not meant* to be fully comprehensive coverages. Additional coverages may have to be bought for additional endorsement fees in order to make the policy complete for a specific insured, and exclusion may also have to be covered by additional or alternative coverage. Likewise, the flood insurance is not covered by private insurance, and much of the trouble that arises in the claims process focuses on claimants—for the first time—understanding the awkward interface between the two totally different insurance mechanisms of

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private insurance and the federal flood program. Further, there are real and legitimate differences between actual cash value and replacement cost values and the reasons for having both within a policy, if only those acceptable differences were better explained up front.

Some of the issues—indeed many, at this point—highlight the dated notions of coverages still being sold by insurers in this country. Living expenses and business interruption coverage being triggered by physical damage, contingent business interruption being triggered by a variety of factors unrelated to the insured, civil authority coverage being wholly inadequate in duration, loss documentation practices not keeping pace with the electronic age, and other realities of today’s typical insurance policy simply are outdated and need to be rethought in order to meet the needs of the twenty-first century insured.

Language in policies, clarity and relevance of coverages, and mutual expectations of insurers and insureds are all issues that need to be addressed. In many ways, public insurance adjusters are referees in the fight over those expectations, played out in the claims process, and what those expectations were initially going into the insurance relationship. Also, those expectations need to be memorialized in policy documents that are not only easy to understand but also delivered in a timely fashion; the notion of contract certainty, a long-held tenant of professional insurance conduct in Europe and elsewhere for decades, still eludes the marketplace in the United States.

One simple way to lend clarity and transparency into the claims process is to better educate the insured public as to the respective roles of the players with whom they will invariably come in to contact during the underwriting and claims processes: let’s have the public, once and for all, understand

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- that a broker works for them but an agent works for a carrier;
- that an independent adjuster is not independent at all and largely works on behalf of insurers, while a public adjuster works for claimants only;
- that business *interruption* coverage oftentimes means business *termination* in order for coverage to attach to a loss;
- that claims should only be handled by licensed public insurance adjusters and not by contractors pretending to be qualified in this specialized profession; and finally,
- that all insurance policies are contracts for the exchange of economic consideration, and there must be some relevance between the premiums charged and the economic security that is expected in return.

If we start with just these simple concepts, we will all move the objective of understanding insurance forward, and from there we can then tackle the more complex issues that we know are still vexing us in the claims process and throughout insurance.

This leads me to one last, albeit more complicated, concept that deserves attention given the context of Sandy as a coastal storm: the hurricane deductible. There is growing acrimony over the determination to treat Sandy as something other than a hurricane and prohibit the imposition of hurricane deductibles upon insureds. In the view of the National Hurricane Center and the National Weather Service, Sandy was not a hurricane at landfall, and hadn't been a hurricane for at least 24 hours prior thereto. Also, sustained wind speeds did not allow for many

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other hurricane deductibles to be triggered. Thus, the decision by insurance regulators up and down the coast was correct, technically, legally, and contractually. Insurers, however, in addition to threatening higher rates and curtailed coverages are also considering a challenge to the meteorological judgments of those most in the know. This present a potentially disastrous scenario for claimants who could, potentially, become the target of claw back efforts by insurers to recoup benefits paid out if it were to be found, however improbable, that Sandy was in fact a hurricane.

The politics of a storm have many believing that the “no hurricane” determination was simply meant to deliver maximum relief to affected insureds with an arbitrary decision; we believe otherwise, and some parameters must be established to minimize the opportunity for any party—regulators, public officials, insurers or even public adjusters—from moving hurricane deductibles from the category of good and effective risk financing mechanism to that of political pawn.

Thank you for your attention to the views of the leadership and members of the National Association of Public Insurance Adjusters. NAPIA remains committed to enhancing both public understanding of and strong regulatory enforcement in the insurance marketplace. NAPIA will do whatever it can to move forward the dialogue started with this hearing.



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December 2, 2012

Hon. Mike Chaney  
Commissioner  
State of Mississippi Insurance Department  
Chair  
Property/Casualty (C) Committee  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106

RE: Public Hearing on Catastrophe Issues

Dear Chairman Chaney:

I want to thank the Committee for including the public insurance adjuster profession in the catastrophe issues hearing today. The issues presented by all the witnesses and the submitted testimony are most important if we are to improve the catastrophe insurance claims process. It is good that you hear from all sides in determining the best path forward, and the National Association of Public Insurance Adjusters is pleased to be part of that dialogue.

### Payment of Public Adjusters' Fees

A question posed during my testimony today regarded public adjusters getting paid directly by insurers without the claimant's approval at the time of settlement. As I indicated in my answer, I see nothing wrong with an assignment being given to the public adjuster at the time of loss. I must be clear, though, that this should only be in reference to the public adjuster's fee and not the entire settlement.

At the time of issuance of the payment the insured should be asked to sign a "Direction to Pay" authorization for only the amount of the adjuster's fee. If the insured is satisfied with the adjuster's performance and would like them paid directly, then it would be appropriate for the insurance company to issue the check without the policyholder's name on it and send it directly to the adjuster; again, the check to the public adjuster would be just for the fee owed to that adjuster.

If the policyholder does not want to authorize the direction to pay, then a check co-payable to the insured and the public adjuster should be issued for the amount of the adjuster's fee. Thereafter, the parties can work out any differences without holding up the balance of the client's monies in settlement of the loss.

Generally speaking, in no event should a public adjuster obtain a Power of Attorney or receive all the funds on behalf of a claimant. The only possible exception to this rule might be in the case of a large commercial enterprise, like a bank or real estate company, that routinely and knowledgably engages the services of a public adjuster for large inventories of properties held. For individual claimants, be they on personal or commercial policies, however, there is never a good reason for a public adjuster to hold that party's power of attorney or insurance proceeds.

### Proof of Loss Expense Coverage

An important point I briefly addressed in my remarks is the issue of policies covering Claim Expense or Proof of Loss Coverage.

Several policies cover the insured's cost to hire people to prepare a claim (they often have sub-limits). Most of these clauses, however, specifically exclude expenses related to the claimant's retention of the services of a public insurance adjuster. This is akin to excluding a broker's commission in the premium for the placement of insurance, or a doctor's fee falling outside of health insurance. Public adjusters, like insurance agents and brokers, are specifically licensed and regulated in 45 states to perform the particular task of assisting insureds in the preparation of their claims.

One unintended effect of this omission is that it encourages people to not obtain a public adjuster's license, or to surrender one they possess. It is actually easier for an unlicensed party, especially one engaged in the unauthorized practice of public adjusting, to have their costs included in the settlement of a claim. We respectfully request that as the public dialogue started with today's hearing continues the NAIC and state insurance departments will look at this prohibiting language and rectify the situation.

I would respectfully request that this correspondence be added to and made part of the record of today's proceedings.

Again, thanks for your interest in our testimony today.

Sincerely,

/s/

Ronald J. Papa

CC: Eric Nordman



# Consumer Perspectives



# POST CATASTROPHE CLAIMS SETTLEMENT

Presented to the P&C Insurance (C)  
Committee, NAIC  
December 2, 2012

*Appointed by*  
JEFF ATWATER  
CHIEF FINANCIAL OFFICER  
STATE OF FLORIDA



## TRANSPARENCY

- ▣ ELECTRONIC CLAIMS FILES AND ADJUSTING RECORDS
  - INTRA-COMPANY AVAILABILITY
  - PUBLIC PORTAL
  - ITEMIZED COST



## KEY STATUTES AND RULES

### Duty to Acknowledge, Investigate, Pay or Deny Claims within Specified Times

- 14 days for communication of receipt
  - 10 days to begin investigation
  - 90 days to pay or deny

### “Anti-Gouging” Law

- Applies for 60 days

### Mediation Program





ROBIN SMITH WESTCOTT, ESQ.  
INSURANCE CONSUMER ADVOCATE

## **POST CATASTROPHE CLAIMS SETTLEMENT FLORIDA' S PERSPECTIVE**

Due to its exposure to hurricanes, many view Florida as the epicenter for catastrophe risk in the country. While Florida has now gone almost seven years without a major storm making landfall in our state, many other regions of the country, including the Northeastern United States, now recognize their exposure to catastrophic risk. As we prepared this review of statutory and rule development in Florida, we found that many of the issues that need to be addressed are not unique or specific to a catastrophe. The event of a catastrophe tends to magnify and multiply the inefficiencies and inequities that can exist in claims settlement practices. More transparency is the key, both for improving consumer relations and improving claims handling processes.

### **Transparency in Claims Settlement**

Transparency and access for the consumer/insured is always at issue. Connectivity with an insured is typically provided by the agent or adjuster having direct communication with the insured. Companies' traditional claims settlement practices often rely upon that communication to "bridge the gap" to the consumer/insured. After a catastrophic event, effective communication with a consumer/insured can deteriorate due to the total disruption and magnitude of managing multiple claims. Many times, the agent force in the affected areas suffer the same types of loss that their consumers/insureds face and adjusters assigned in the field may change as the insurance company deals with deploying and managing adjusters under contract for post-catastrophe events. One recommendation is for companies to maintain all claims files and adjustment records electronically with some interface for consumers/insureds to review and submit documentation. This would allow for key personnel throughout an organization to have access to the claim information. A public interface would also facilitate the ability of the consumer/insured to be more informed and involved in the process and help avoid disputes resulting from lack of documentation or misinformation. In addition, insurers should provide detailed, itemized claims adjusting estimates, including quantity and price of construction items, so that insureds and their contractors are able to better understand the estimate and identify any areas of disagreement. The claims settlement process is often a mystery to the consumer/insured,

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even in a non-catastrophe environment. Greater transparency would help demystify the claim settlement process for consumers and bridge the communication gap after a catastrophe.

## **Key Florida Statutes and Rules Affecting Claims Handling Practices**

The following is a summary of statutory changes affecting claims handling, most of which were in response to problems arising after Florida's hurricanes in 2004 and 2005. However, as noted, some had unintended consequences that required further revisions.

### **Requirements for repair or replacement coverage (s. 626.9744, F.S.)**

*Unless otherwise provided by the policy*, if a homeowner's policy provides coverage based on repair or replacement costs:

- If the replaced items do not match in quality, color, or size, the insurer must make reasonable repairs or replacement of items in adjoining areas.
- Any damage incurred in making repairs or replacement must be covered, up to applicable limits.

*Background:* Enacted in 2004, to address consumer problems with property insurance claims for which the insurer would not cover replacement of undamaged areas such as tile floors, when the new tiles for the damaged area did not match in color or size to the undamaged tiles. An unintended consequence later arose resulting in an escalation of claims from fraud and abuse. Small areas of damage of a floor led to replacement of floors for the entire home if the insurer could not obtain exact matches for the damaged area. While not addressed legislatively, many companies adopted sub-limits in the policies for such damage in order to cap the amount of the claims.

### **Replacement Cost Coverage; Holdback of Depreciation in Value (s. 627.7011(3), F.S.)**

2005 Law:

- For a loss insured for replacement cost, required the insurer to pay the replacement costs without holdback of any depreciation in value, whether or not the insured replaces or repairs the dwelling or property.

*Background:* Over the objections of the insurance industry, the Legislature determined that a consumer should not be required to actually replace or repair property if the consumer purchased replacement cost coverage. Regulators had received complaints from policyholders with replacement cost coverage who were paid actual cash value but could not afford to fund the balance necessary to make the repairs or replacement. For example many roofs could not be repaired because the demand surge after the 2004 hurricanes led to consumers competing for roof repairs, and roofers contracting with the highest bidder. Also, some insureds could not secure a contract for repair without knowing that the company would in fact pay the full replacement cost.

Current Law (enacted in 2011):

- Revised the 2005 law on how insurers must pay dwelling or personal property losses on a replacement cost basis.
- For a **dwelling** loss, the insurer must initially pay the actual cash value, minus the deductible. Subsequently the insurer must pay any amounts necessary to perform repairs as work is performed. If a total loss of a dwelling occurs, the insurer must pay the entire replacement cost coverage without holdback of depreciation in value pursuant to the Valued Policy Law.
- For **personal property** losses insured on a replacement cost basis, **the insurer must offer two claim payment options:**
  - The first option requires the insurer to pay the replacement cost without holdback of depreciation, regardless of whether the insured replaces the property.
  - The second option allows the insurer to limit the initial payment to the actual cash value of the personal property to be replaced. To receive payment for the full replacement value, the insured must provide a receipt for the replaced property to the insurer. (For this option, the insurer must provide a premium credit or discount and the insurer must provide clear notice of the payment process before the policy is bound.)

*Background:* Insurers needed to increase premiums for replacement cost coverage due to the 2005 act. Claims costs increased since claimants were no longer required to make repairs or replace damaged personal property before receiving full replacement cost. Insurers also alleged that this resulted in inflated and fraudulent claims. The need for a distinction between a dwelling loss and personal property loss became evident after the rise of sinkhole claims in Florida. The 2005 law may have actually incentivized fraud and abuse in filing claims like sinkhole claims where damage and causation are difficult to evaluate and establish. There is also a strong public policy argument that dwellings should be repaired for future insurability and to prevent diminution of property value.

**Duty to Acknowledge, Investigate, and Pay or Deny Claims within Specified Time Periods (ss. 627.70131, and 626.9541(1)(i), F.S.)**

Section 627.70131:

- Within 14 calendar days of receipt of a communication with respect to a claim, a residential property insurer must review and acknowledge receipt of such communication, unless the failure to do so is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment.
- Unless otherwise provided in the policy, within 10 working days after a residential property insurer receives proof of loss statements, the insurer must begin investigation as is reasonably necessary unless the failure to do so is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation.
- Within 90 days after a residential property insurer receives notice of an initial, reopened, or supplemental property insurance claim, the insurer must pay or deny the claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment. Any payment made 90 days after the insurer receives notice of the claim, or made more than 15 days after there are no

longer factors beyond the control of the insurer which reasonably prevented such payment, whichever is later, bears interest at the statutory rate of interest required for legal judgments, from the date the insurer receives notice of the claim.

Section 626.9541(1)(i), F.S.:

- A separate Florida statute provides that it is an unfair insurance practice for an insurer to fail to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after determining the amount and agreeing to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed. Violations are grounds for a private civil remedy action, due to the cross-reference in s. 624.155, F.S.

*Background:* Since the hurricanes of 2004 and 2005, there have been consumer complaints of insurers not paying or denying claims within a reasonable period of time. However, legislative attempts to address this in 2005 proved to be controversial and merely resulted in codification of rules adopted by the Office of Insurance Regulation, requiring insurers to review and acknowledge receipt of a claim within 14 days, and to begin an investigation within 10 working days after receiving proof of loss statements (summarized in the first two bullets above). Then, in 2007 (House Bill 1-A), summarized in the third bullet above, residential insurers were required to pay or deny claims within 90 days, unless the failure to pay was caused by factors beyond the control of the insurer. The following year, in 2008, a stronger requirement was enacted for insurers to pay undisputed amounts within 90 days, by being placed in a provision of the unfair insurance trade practice section that is cross-referenced in the civil remedy statute (s. 624.155, F.S.) which allows a private cause of action if violated.

**Licensure of Emergency Adjusters (s. 626.874, F.S.)**

- In the event of a catastrophe, the Department of Financial Services may license emergency adjusters who have been designated and certified as qualified to act as adjusters by an all-lines resident adjuster, authorizer insurer, or licensed general lines agent, under the conditions and for the period of emergency as the department shall determine.

*Background:* This is an old law predating Hurricane Andrew, which has been used by the Department for emergency licensure of adjusters after a hurricane.

**“Anti-Gouging” Law (s. 501.560, F.S.)**

- Makes it unlawful for any person to charge an unconscionable price for an essential commodity within the area for which the Governor has declared a state of emergency.
- Applies to supplies, services, provisions, or equipment necessary for consumption or use as a direct result of the emergency, including, but not limited to, food, water, ice, chemicals, petroleum products, lumber, rental or dwelling units.

- Prima facie evidence that a price is unconscionable if the amount charged represents a gross disparity from the average price during the 30 days prior to the declaration of a state of emergency.
- Applies for 60 days, subject to renewal in any subsequent renewal of the declared state of emergency by the Governor.

*Background:* Enacted after Hurricane Andrew in 1992 in response to significant price increases some merchants and vendors charged for essential commodities and temporary housing after the storm.

**Mediation Program for Disputed Property Insurance Claims (s. 627.7015, F.S.; Rule 69J-166.031, Fla. Admin. Code)**

- Non-adversarial, informal dispute resolution program for property insurance claims for which the amount in dispute is \$500 or more.
- Initiated by DOI Emergency Rule in 1992 after Hurricane Andrew and codified in 1993 (s. 627.7015, F.S.) to help consumers resolve property insurance claims.
- Series of DFS Emergency Rules in 2004 and 2005 implemented the mediation program for the eight hurricanes hitting Florida, for which over 2.5 million property insurance claims were filed.
- A DFS permanent Rule (69J-166.031, F.A.C.) was adopted in 2009 implementing the mediation program. Further emergency rules for the program are not believed to be necessary. (Prior emergency rules also included specific construction price guidelines, but were difficult to develop and needed to be addressed on a case by case basis.)
- A policyholder (or insurer) may request mediation of a claim by contacting the DFS Division of Consumer Services. The insurance company then has 21 days to resolve the dispute.
- If a settlement is not reached, mediation is scheduled by a contract administrator. The insurer pays a flat \$350 fee (\$250 to mediator; \$100 to contract administrator).
- Mediation is an informal process lasting about 1-2 hours where a Florida Supreme Court certified mediator helps the policyholder and insurance company focus on the issue in dispute and facilitate an amicable resolution of the dispute. The insurer representative must have fully authority to settle the claim.
- Many of these disputed claims involved issues related to adjusting mistakes, fluctuating construction prices, confusion over policy coverage, poor documentation of loss, or communication problems between the insurance company and the policyholder.
- Results of 2004-05 storm claims: 25,122 mediation cases – 86% settlement rate (including partial settlements) and 14% impasse rate.

**Preferred Building Contractors (s. 627.7016)**

- Florida law allows residential property insurers to contract with a building contractor skilled in techniques that mitigate hurricane damage and to offer policyholder the option to use such contractors to repair covered damage. The insurer must guarantee the contractor's work and may offer other terms or benefits.

*Background:* Enacted in 1996 to facilitate reconstruction and repair claims, but we understand that it has not been widely utilized by insurers.

### **Emergency Rules in 2004 or 2005**

- Required insurers to settle and pay all claims outstanding on Dec. 31, 2004, by April 18, 2005, and to provide a report and explanation on claims not settled by that date.
- Prohibited insurers from canceling or nonrenewing a residential property insurance policy if the dwelling was damaged by a storm and a claim was payable, until 60 days after the dwelling was repaired, with allowable exceptions. (Note: There is now a statutory requirement in s. 627.4133(2)(d), F.S., prohibiting insurers, upon issuance of a declaration of an emergency, from canceling or nonrenewing a residential policy covering a dwelling damaged by hurricane or wind loss for a period of 90 days after the dwelling has been repaired.)
- Extended time periods for policyholders in affected counties to meet any policy deadline for performing any act or paying premiums (generally, up to 65 days).
- Prohibited cancellations or nonrenewals of any type of insurance policy in affected counties for a specified period (generally, 65 days).

### **Additional Issue – Time Limits on ALE and Replacement of Property**

Consideration should be given to extending time limits for coverage under a residential policy, specifically for additional living expenses and replacement of personal property. It is not uncommon for consumer/insureds to be displaced for extended periods of time after a catastrophe. Many policies have one-year time limits for payments under these provisions, which may be too limiting for consumers in certain situations. If a consumer/insured is not back in their home within the one-year limit, it can be very difficult and costly for them to replace their personal items and store them in another location. It also poses a tremendous financial hardship for consumers to maintain a separate residence without the additional living expense benefit. Florida has not addressed this issue but this could be accomplished by changes to policy forms without need for legislative changes.

## **Conclusion**

In conclusion, Florida has struggled to resolve many of these post catastrophe claims settlement issues. The foregoing statutes and rules may be helpful in the development of model laws and best practices for the insurance industry. However, there will always be new challenges for handling claims after a catastrophe. Overall, the key is greater transparency in the claims handling process, which would empower consumers and help insurers better serve their policyholders.

# Regulatory Perspectives



**DEPARTMENT OF INSURANCE**

CONSUMER SERVICES & MARKET CONDUCT BRANCH  
TONY CIGNARALE, Deputy Commissioner  
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**Date:** November 20, 2012

**To:** Property and Casualty Insurance (C) Committee

**From:** Tony Cignarale, Deputy Commissioner, Consumer Services & Market Conduct

**Subject:** California Department of Insurance (CDI)  
Public Hearing on Catastrophic Claims  
NAIC Fall National Meeting, Washington, D.C.  
Sunday, December 2, 2012

Over the past 20 years, California has experienced significant catastrophic losses, resulting in the tragic loss of life and property. In addition to the devastating losses from the 1994 Northridge EQ, several thousand residences, businesses, and other structures were lost due to wildfires, from the 1991 Oakland, CA wildfire to several major firestorms throughout the state. Based on this experience, CDI worked with insurers, consumer groups, local government, and the state Legislature to craft several significant achievements to protect policyholders.

**1. Extension of Replacement Cost and ALE Time Limits:**

First, after a major event, it is virtually impossible for the homeowner to rebuild the destroyed property in the typical six months or one year to rebuild and replace the structure, contained in most HO policies. We found many homeowners were losing out on both full Replacement Cost and Additional Living Expenses (ALE) since they could not meet these deadlines. California passed legislation to require after a "state of emergency," that these time periods to collect full RC and ALE to at least 24 months, with extensions for good cause. **California Insurance Code (CIC) Section 2051.5(b).**

**2. Ability to Replace by buying a new home, rather than rebuild in the current location:** After a major event many homeowners will either not be able to rebuild at the current location due to the continuation of the hazard, new zoning limitations, or by their own choosing. In these cases, insureds were losing out on full Replacement Cost (only getting ACV) when they decided to purchase a replacement home rather than rebuild. California passed legislation to require payment of full replacement cost even if the insured purchases another home rather than rebuild. **CIC section 2051.5(c).**

**3. Lost Policies After a Loss:** Getting a copy of a destroyed insurance policy is an important first step in the claims recovery process. California passed legislation to



require that, after a loss, the insurer provide a copy free of charge within 30 days of the request. **CIC Section 2084(a).**

**4. Protection from being Cancelled or Non-Renewed after a Major Loss:** After a major loss, some insurers would cancel or non-renew the insurance policy. This caused severe hardship to homeowners, who had to go without any insurance protection or had their lenders force place expensive lenders coverage. California passed legislation to prohibit cancellation or non-renewal of the policy during the period to rebuild. **CIC section 675.1.**

**5. Mediation Program Expansion from just EQ to all catastrophic HO Claims:** California passed legislation to allow for non-binding mediation, using independent and experienced mediators, between the insurer and the claimant. The cost of the program is paid for by the insurer. This program has resulted in many settlements of disputed claims, thus avoiding costly and time-consuming litigation. **CIC Section 10089.70.**

**6. Underinsurance:** Underinsurance was certainly prevalent after each and every major event. California's experience reflects that this phenomenon is caused by a combination of demand surge (lack of available contractors and building materials in a certain area) and inadequate insurance coverage or coverage limits under the homeowner's insurance policy. CDI found that certain components of replacement value may not have been considered at all, or have not been considered fully, in determining replacement value estimates, when the policyholder purchased coverage. These omitted components include costs to replace the foundation of the structure; debris removal and demolition expenses, overhead and profit, engineering reports and architects plans. Additionally, full consideration of the type of frame, roof, siding, slope, size, square footage, location, stories, wall heights, materials, and age would provide a more accurate estimated replacement value. In 2011, CDI adopted regulations that provide more comprehensive and reliable estimates of what it might cost to completely rebuild a destroyed home. Such estimates were previously unregulated, and led homeowners to believe they needed less coverage than they truly did in the event of a disaster.

These regulations require all California resident broker-agents to satisfactorily complete one three-hour training course on homeowners' insurance valuation prior to estimating the replacement value of structure and require that all replacement cost estimates communicated to applicants or insureds be complete, based upon specifically enumerated standards.

**7. Other Proposed Claims Handling Reforms Adopted by Insurers on a Voluntary Basis:**

CDI negotiated with the major insurers, who agreed to implement voluntary claims reforms for post-disaster losses. These reforms included:

**Additional Living Expenses:** Insurers should adopt a standard ALE advance payment of 4 months for a total loss, upon request. Additional ALE should be available upon proper proof following the advance period, upon request.

**Vehicle claims:** Upon satisfaction of proof of claim, insurance companies should expedite payment of automobile property damage claims under comprehensive loss coverage.

**Contents:** Insurers should provide a standard contents advance payment of at least 25% of policy limits for a total loss of the primary residence in a wildfire disaster.

**Billing:** All insurers should grant billing leniency for 30 days for customers in designated wildfire disaster areas.

**Debris removal:** Insurers should accept an expedited debris removal process coordinated through city, county and state agencies, with master debris removal vendor contracts under pre-negotiated conditions. In this pre-negotiated environment, insurers would agree to pay debris removal bills promptly.

**Inventory Itemization:** Insurers should agree to accept reduced itemization of contents in wildfire total losses.

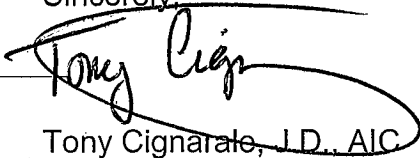
The California Department of Insurance appreciates the opportunity to present testimony on this important issue and extends its full cooperation in any next steps by the NAIC in furthering the goal of protecting policyholders after a catastrophic claim.

Should the committee wish further information on these topics please contact Tony Cignarale or Joel Laucher:

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Sincerely,



Tony Cignarale, J.D., AIC  
Deputy Commissioner  
Consumer Services & Market Conduct Branch



# Insurer Perspectives





AMERICAN  
INSURANCE  
ASSOCIATION

**NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS  
HEARING ON CATASTROPHE CLAIMS  
DECEMBER 2, 2012**

**STATEMENT OF THE AMERICAN INSURANCE ASSOCIATION**

## **INTRODUCTION**

The American Insurance Association appreciates this opportunity to provide testimony to the NAIC Property and Casualty (C) Committee on the important subject of catastrophe claims. The AIA represents 300 leading property and casualty insurance companies. In the United States alone AIA members write more than \$117 billion in premiums annually.

Whether a claim involves a minor fender bender or a complicated commercial loss following a major catastrophe, AIA members work not merely to meet consumer expectations but to exceed them. While the claims process can at times be challenging for consumers, AIA members work hard to make it as understandable and smooth as possible while simultaneously working to meet their legal, regulatory and business obligations.

Thus, AIA members have a wealth of experience with catastrophe response, its challenges and resulting regulations. This experience also influences our opinion that there is a need for better regulatory communication, clarity and consistency following a disaster. However, it is important to consider that certainty achieved through uniformity in insurance products is not consumer friendly when it suppresses consumer choice. We look forward to a constructive dialogue aimed at improving catastrophe response for insurers, consumers and regulators alike.

### ***EVEN AS WE TESTIFY AIA MEMBERS & THEIR RESOURCES REMAIN FOCUSED ON RECOVERY FROM THE SUPER STORM***

We are, of course, testifying in the midst of a major disaster recovery in which thousands of insurer representatives are working on claims throughout New York and New Jersey and other parts of the Northeast. The Super Storm is just the latest reminder of the challenges catastrophes pose to our country. Whether it was 9/11, the 2004 storms in Florida, Hurricane Katrina, the Northridge Earthquake or, now, the Super Storm, insurers stand ready to perform on their promises.

Insurers have had thousands of people working on Super Storm claims. Many insurance claims professional have left their own homes behind for extended periods in order to work 14 hour days 7 days a week. Indeed, many insurers even had mobile claims units open on Thanksgiving Day. Moreover, in the immediate aftermath of the Super Storm and even before they received regulatory guidance, insurers took many steps to aid consumers including not applying hurricane deductibles because contract language was not triggered, imposing moratoria on premium collections and nonrenewal or cancellations of policies, and engaging in substantial charitable assistance.

At the same time, insurers have been actively working with regulators to help speed recovery efforts. Hundreds of insurer public policy professionals have participated

countless meetings, calls and email distributions for the past 5 weeks to make sure insurers are well informed and are providing the best information they can to regulators, decision makers and the public. We have collaborated with regulators on myriad matters from claims handling to data needs to underwriting issues. Simultaneously AIA and our members have sought to provide regulators with real time feedback on the many issues insurers and policyholders confront as we work together through the aftermath of the Super Storm.

While we focus on recovery over the years, AIA and its members have gained many insights on catastrophe insurance and response. One lesson learned is the continuing need for people ready to work in catastrophe claims. To that end, AIA's members recently completed a multiyear process that culminated in an educational partnership with the Institutes. The Institutes (formally known as The Insurance Institute of American and the American Institute for CPCU) are America's preeminent nonprofit educators of insurance professionals. This partnership has now produced course work that will educate potential insurance professionals specifically in catastrophe claim fundamentals so in the future they may assist our industry in catastrophe response.

So even as catastrophe response continues, AIA and our members continue to derive lessons to strengthen future responses and our collaboration with policyholders, regulators, and public policy decision makers. Thus, it is fitting to be here today to examine catastrophes.

### ***PROTECTING CONSUMER CHOICE IS CONSUMER FRIENDLY***

Many of the questions in the hearing notice suggest that regulators may desire greater uniformity amongst insurance products. We would, of course, caution that some such efforts could unintentionally harm a fundamental consumer benefit—policyholder choice. Thus, while we could go far with the notion of greater consumer certainty or uniformity, policyholders could pay for that decision with fewer choices.

For example, we already know that some consumers want flood insurance and some do not. They are, of course, making their own choice, their own valuations between the costs and risks. Similarly, some consumers want longer term additional living expense coverage; while others do not, probably figuring they can save money and live with families and friends—sort of self help. And, we of course know from our experience that some consumers want percent deductibles, seemingly deciding they'd prefer a lower premium now and to self insure some of their risk, while other consumers may want a smaller personal exposure to a loss and are willing to pay more to get that.

So, we must not lose sight that efforts that could lead to homogenizing insurance can come at a price to both the product diversity and availability that consumers demand, and the costs that consumers want. For example, if suddenly every wind driven flood is a covered wind event, that will have unintended consequences for consumers.



At the same time, mandating uniformity in products will strip some insurers of hard won advantages in the marketplace. No longer will insurer X be unique or better if its advantages are taken from it by forcing them on the entire market place. So such steps could adversely impact the market by discouraging competition and market entry.

Nonetheless, there are things regulators can do to help prepare for the next catastrophe. They can help improve flood insurance and earthquake take up rates. Much of the problems arising out of coastal mega storms like Katrina and Sandy are the result of flooding and the absence of flood insurance. Similarly, experts predict that we will have large, devastating earthquakes; that it is merely a matter of time. Regulators could collectively mount educational campaigns similar to what FEMA does for the flood program. Informing consumers can be a simpler, better approach than homogenizing products and removing consumer choice.

***POSSIBLE MODEL GUIDELINES, WHITE PAPERS OR BEST PRACTICES  
MUST BE THOUGHTFULLY CONSIDERED***

The hearing announcement presents a variety of areas for the consideration of possible model guides, white papers or best practices. While the topics under consideration are important, we believe robust markets are the first and best way to achieve much of what is desired. Thus, in most instances, because model guidelines or best practices would set up uniform standards that may limit consumer choice or discourage competition, we believe these work products may be counterproductive and certainly premature. We recommend that any formal NAIC action be limited to white papers examining the issues and educating consumers as an appropriate, first step to considering the many issues identified in the notice.

Moreover, all stakeholders should have ample opportunity to provide input into such whitepapers in order to derive the best, most accurate discussion on a given topic. That approach was invaluable in the NAIC's development of the Defective Drywall paper and permitted stakeholders to correct numerous potential misunderstandings regarding the nature of that issue.

As for the specific topics under possible consideration we have a number of observations as follows:

• ***Appropriate duration of payment of ALE expense.***

As already examined, homogenizing regulatory mandates on additional living expense coverage could drive out choice and expand costs.

• ***Appropriate duration for consumers to recover the full replacement cost of personal and real property***

Again, a mandate that homogenizes a more expansive form of coverage could drive out choice and expand costs

- ***Streamlined inventory requirements in the event of a total loss***

We are not aware that inventories or schedules of loss items are a serious problem. Insurers, states and the NAIC do, of course, have resources to aid consumers in compiling losses, for example free home inventory software or spreadsheets. In addition to permitting insurers to calculate claims more quickly, inventories of loss items are an important hedge against fraud and insurance crime. These important attributes must be weighed against any potential changes to or mandates on loss inventories.

- ***Enhanced training requirements regarding calculation of accurate dwelling replacement values***

Dwelling valuation is an important issue and any proposed changes must be thoughtfully considered to avoid unnecessarily impacting long established business practices or driving out competition.

- ***Requiring insurers to provide a complete copy of a policy upon request as part of claim settlement process***

We do not believe this is a problem; we believe our members and other insurers more generally already do this.

- ***Providing claimants access to copies of all claim-related documents in a claim file***

While seemingly well intentioned, we believe over breadth here could result in problems for privileged documents and could compromise fraud, arson or criminal investigations. This should be narrowly tailored to protect vital legal interests.

### ***IMPROVING CERTAINTY FOR INSURERS AND REGULATORS IS NEEDED IN CATASTROPHES***

We appreciate the NAIC's inclusion of the second set of issues in the hearing notice that relate to insurer uncertainty. As we examine consumer concerns we too must address insurer needs for greater certainty and clarity in the post-catastrophe regulatory environment.

The lack of regulatory clarity and certainty is not new. After Hurricane Irene, AIA accounted over 157 pronouncements of interest from the federal government, 13 states and DC, nearly a third of which (50) were aimed directly at insurers and their business activities. These pronouncements covered an extraordinary array of insurer functions including: Insurer underwriting moratorium; Insurer Cat Plans; Adjuster Licensing;

Claims Handling; Applications of Deductibles; Premium Grace Periods; Moratorium on Premium Increases; and Data Calls.

While the issues covered are largely the same, of 114 pronouncements AIA is following after the Super Storm 80, or 70%, are aimed at insurer business practices. Amongst these pronouncements there is, of course, substantial variability that results in uncertainty and lack of clarity. Moreover, these tracked pronouncements only represent instances in which there was some quantifiable written direction of some kind. There are, of course, many, many more unwritten and unquantifiable communications and directives.

Thus, in an event like Super Storm Sandy, insurers are often hearing and receiving pronouncements from many jurisdictions on many issues even simultaneously. In many instances they are receiving regulatory demands and guidance from multiple sources even within each state. At the same time, regulatory demands and guidance for insurers are circulating via word of mouth, emails, conference calls, bulletins, orders, regulations and even press releases. Complicating this environment further, is a sometimes stated reluctance, perhaps even outright refusal, by a regulator to memorialize something in writing. Not surprisingly, such an environment can be rife with “regulatory hearsay” in which regulators produce information that, while responsive and appreciated, may not be definite and is neither public nor final. *While we are grateful for all communications*, insurers need regulatory clarity and finality to operate effectively.

### ***The need for greater finality in regulatory communication***

Simply put, insurers and indeed policyholders need better regulatory communication and greater regulatory clarity and certainty to perform as they want to in post-catastrophe environments. Clear, concise, final and publicly available written directives referencing supporting law should closely follow the necessary but informal communications insurers have with regulators, and such directives will be the single best way to dispel uncertainty.

An example of regulatory hearsay after Super Storm Sandy was homeowners insurance hurricane deductibles. To our knowledge many insurers are simply not applying them because the relevant contract language was not triggered, and many made this decision even before any regulatory directive and certainly afterwards as we worked with our regulatory partners.

What is less well known, however, is the sheer variety of ways insurers learned or heard about regulatory guidance on hurricane deductibles—in a few instances via bulletins or orders but also by word of mouth, emails, conference calls, and even in press releases. While, of course, we want to have conference calls and emails and greatly appreciate the efforts put in by regulators in producing them, insurers need the certainty of a simple, final declarative writing.

Moreover, there is substantial variability from state to state on these important issues. As regulated entities who must respond to claimants, reinsurers, regulators and shareholders it does not provide greater clarity or greater certainty when insurers must answer to such diffuse approaches without finality. It only increases the potential for miscommunications that can potentially lead to some early misunderstandings.

***Prepositioning guidance is only as good as its certainty and finality***

Some have suggested that prepositioning regulatory guidance would be preferred. While we are generally supportive of the concept, such efforts will only increase the goals of clarity and certainty if the guidance is final **and** holds after an event. If, instead, such guidance becomes just a floor without a ceiling or walls, it becomes unconfined, and no clarity or certainty will be gained. Insurers need regulatory finality, certainty and clarity to plan and position themselves for the best possible response to their consumers and regulators. Continued lack of regulatory clarity and regulatory certainty are bad for consumers, insurers and regulators alike.

***Examples of good efforts to increase regulatory clarity and certainty***

There are examples of regulators that have understood the pitfalls of regulatory hearsay and have worked to improve regulatory communications, clarity and certainty for catastrophes.

For example The NAIC NE Zone members are to be commended for their recent efforts to bring greater uniformity to data calls. Most states in the region impacted by Super Storm Sandy are using the common template and that and future such efforts will improve certainty and clarity. Nonetheless, not all states in the region are using the template and so uniformity remains a goal.

Not surprisingly, states with greater catastrophe experience have understood the problems with regulatory hearsay and the need for regulatory clarity and certainty. Florida and Louisiana, both no strangers to storms like Super Storm Sandy, have worked to improve regulatory communications and finality and they have lessons learned to share on the subject.

For example, Florida has statutory and regulatory guidance aimed at improving regulatory communications and certainty and avoiding some of the pitfalls from regulatory hearsay. While perhaps not as fulsome as needed, F.S.A. § 252.63, does provide established guidance on the issuance of emergency orders, their duration and publication after a catastrophe. Similar pre-positioned post-event regulations could improve certainty and clarity. Again, however, such pre-positioned catastrophe claims laws will only provide certainty and clarity if they have longevity. If, however, pre-positioned guidance is subject to constant changes than certainty and clarity will not be obtained.

## ***POSSIBLE MODEL LAWS, REGULATIONS OR GUIDELINES TO AID CERTAINTY FOR INSURERS AND REGULATORS***

The hearing announcement presents a variety of areas for the consideration of possible model laws, regulations or guidelines. While the topics under consideration are important, we believe the NAIC must consider any such models with great deliberation and with an eye toward whether they will actually improve communication, clarity and certainty.

As for the specific topics under possible consideration we have a number of observations as follows:

- ***Standardized insurer premium collection procedures***

Insurers can and do support premium grace periods that are well-crafted and limited to a reasonable period of time. Premiums are, of course, necessary for insurer operations. A limited grace period for policyholders with residences or business impacted by the storm, rather than state wide or countywide moratoria are preferable. Moreover, a large corporation should not get a premium grace period simply because it has one impacted property when the balance of its properties are not impacted or are even out of state.

- ***Underwriting Limitations***

Insurers can and do support reasonable limitations on post catastrophe business decisions about insureds, cancellations, nonrenewals, and premiums that are properly tailored. To avoid unintended consequences, however, such limitations should:

(1) only be for insureds actually impacted by a catastrophe and again, not large corporations;

(2) only restrict cancellation or nonrenewal on nonpayment of premiums (other reasons such as criminality, arson, fraud should, of course, remain); and

(3) be limited in time, for example 30-60 days.

Approved or permitted rate increases or decreases should be allowed though premium payments may remain suspended. In all situations policyholders should not be precluded from cancelling or nonrenewing or making necessary changes to coverage.

- ***Claims Handling Processes***

Regulators should take affirmative steps to speed claims handling and processes and avoid unintended harm to insurers as they are seeking to help policyholders.

Adjuster access is critically important and we routinely here that adjusters are not able to access properties even when residents are being permitted to. This will slow claims processing. In addition specialized identification for adjusters may help. Finally, insurers should not be automatically penalized for not complying with prompt claims handling deadlines if delays were not their fault. Access is critical and in mass catastrophes, like Katrina and the Superstorm, delays outside the insurers' control should not result in penalties. Such automatic penalties are unfair and discourage insurers.

- ***Claims Data Reporting***

Lack of uniformity and constant changes in claims reporting elements combined with short and/or changing deadlines make it very hard for insurers. The NAIC NE Zone is to be applauded for some of its members' efforts to provide data uniformity coupled with deliverability.

Ideally, we would, of course, like to see a standardized, uniform and prepositioned catastrophe claim data call used throughout the US. Again, however, such an effort at standardization will only be meaningful and only meet the goals of certainty and efficiency if it holds up in the post-event environment. If, instead, a prepositioned data call is subject to constant or even occasional changes when considered across a number states, then efficiency and certainty will not be achieved.

Data elements that are not available or which require manual, file by file review of thousands of claims files to find data that is incomparable in any case will be of little value and will unnecessarily complicate insurer's responses in a post-catastrophe environment. Manual file reviews will divert insurer resources. In this regard we applaud Massachusetts's choice last year to permit file sampling after Hurricane Irene and tornados rather than requiring a file pull and review of each of many thousands of claims. Moreover, regulator imposed computer coding changes to sift data, even apparently simple ones, can be very expensive and time consuming and may not even produce meaningful or comparable data.

Finally, for insurers there is also concern that their individualized data will be prematurely released to the public notwithstanding laws and pronouncements pledging that such information will remain confidential and only used internally and, if released, only done so in the aggregate. Such fears are not without some support given insurer experiences. The problem, of course, is that early data is just that, early data. It is an early snapshot and things can and do develop and clarify; thus the data may not present an accurate picture of the circumstances presented. Moreover, data elements are often undefined and thus data is not even comparable. Insurers remain keenly interested on producing accurate, deliverable data that is protected so regulators can do their jobs without jeopardizing the job insurers must perform as well.

## ***CONCLUSION***

Insurers need clarity and certainty to improve performance. Moreover, consumer choice is not a bad thing; if we rush to provide uniformity in products we may limit the choices consumers want and prices they can accept. AIA and its members stand ready to work with all stakeholders to find common ground on ways that we may improve the catastrophe claims environment. As that unfolds, however, our work continues to meet the needs of our policyholders impacted by Super Storm Sandy.



STATEMENT OF THE  
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES  
TO THE  
NAIC'S PROPERTY AND CASUALTY (C) COMMITTEE  
PUBLIC HEARING ON CATASTROPHE CLAIMS  
DECEMBER 2, 2012



## **Introduction**

Thank you for the opportunity to provide testimony to the Property and Casualty (C) Committee on the subject of catastrophe claims issues on behalf of the National Association of Mutual Insurance Companies (NAMIC). NAMIC members are 1,400 property/casualty insurance companies serving more than 135 million auto, home, and business policyholders, with more than \$196 billion in premiums accounting for 50 percent of the automobile/homeowners market and 31 percent of the business insurance market. We are the largest and most diverse property/casualty trade association in the country, with regional and local mutual insurance companies on main streets across America joining many of the country's largest national insurers who also call NAMIC their home. More than 200,000 people are employed by NAMIC members.

NAMIC views this hearing as a valuable opportunity for constructive dialogue among members of the property and casualty insurance industry and regulators on claims issues that arise in the wake of a catastrophic event. We believe there is an opportunity for industry and regulators to operate in a more collaborative fashion to serve insured consumers.

## **User-friendly Post-Disaster Claim Practices**

Where the hearing notice's first section invites discussion on "how to make post-disaster claims-settlement practices more user-friendly," we would like to suggest at the outset that, as they exist today, claims settlement practices are already extremely consumer-friendly. Our members are acutely aware that when a catastrophe occurs, it is time for them to step up and meet their obligations to swiftly process and pay claims. They recognize that this is why their policyholders purchased coverage in the first place, and they take this responsibility as seriously as could be imagined.

Our members strive not just to meet their contractual obligations, but to exceed expectations in service of their policyholders. Operating in a competitive environment, they continually engage in innovation to make the claims process as consumer-friendly as possible.

To be sure, those who are victims of catastrophic loss face difficulties ranging from the inconvenient to the tragic. And there are aspects to the claims process that are by their nature complex and potentially challenging. But companies strive to serve their customers in these times as best they can, and they do a remarkable job of achieving positive results in these trying times.

The recent success of insurers in responding to consumers' needs following catastrophes was authoritatively documented by a third-party analysis in J.D. Power and Associates 2012 Property Claims Satisfaction Study.<sup>1</sup> The study focused on the impact of higher-than-normal catastrophe

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<sup>1</sup> Available at [http://img.en25.com/Web/JDPower/2012\\_PCS\\_MD.pdf](http://img.en25.com/Web/JDPower/2012_PCS_MD.pdf).

losses in 2011, and its authors expected to find lower satisfaction levels due to the increase. Instead, they found just the opposite. Not only did satisfaction levels not decline in the year, they actually saw the largest increase during the 5-year period in which the study was conducted. We would suggest that this study represents unbiased evidence that insurers perform extremely well when it comes to serving insureds through the claims process following a catastrophe.

Additional evidence of insurers' excellent post-disaster performance can be found in analyses and statements of state regulators themselves.

In May of this year, the Massachusetts Division of Insurance released an analysis of the claims resulting from regionally rare tornadoes that produced catastrophic damage to homes, businesses and property in portions of Western and Central Massachusetts a year earlier.<sup>2</sup> The analysis of results for the top 25 home insurance companies and FAIR Plan documented that, of more than 11,000 claims totaling nearly \$200 million, more than 98 percent were processed within 120 days of the tornadoes.

In Connecticut, state officials reported that Tropical Storm Irene resulted in more than 60,000 claims totaling \$235 million, and the number of claims disputed enough to result in complaints to the Insurance Department's Consumer Affairs Division amounted to a fraction of one percent of those claims, a record that prompted the Division's manager to describe the industry's performance as "very good."<sup>3</sup>

Both examples demonstrate that insurers perform well following a catastrophe, processing claims as quickly as possible for the benefit of their insureds. Together with the customer satisfaction findings presented by J.D. Power and Associates, they make a compelling case that as they exist today, post-disaster claims practices are indeed consumer-friendly. This is not to say that they cannot become better, and indeed our members are constantly evaluating existing practices to determine if consumer-friendly innovations can be made. We are hopeful that this hearing produces ideas that can further benefit consumers in a post-disaster environment.

When it comes to some of the items specified in the hearing notice, we would suggest that not all but some of them would carry associated costs. It is always a challenge for consumers to balance coverage and cost considerations when making insurance-purchasing decisions, and we would caution against any outcome to these hearings that would be too prescriptive or restrictive so as to limit a consumer's choice.

### **State Government Actions Following a Catastrophe**

Where the second section of the hearing notice raises the issue of "diverse regulatory mandates" following a catastrophe that might "divert resources that are needed to respond to claims," we

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<sup>2</sup> "The June 1, 2011 Massachusetts Tornadoes: A Special Examination of Property and Casualty Insurer Claims Payment Practices," May 22, 2012, available at <http://www.mass.gov/ocabr/docs/doi/final-report-2011-tornadoes.pdf>

<sup>3</sup> "After Irene, Insurance Lessons Learned," *Hartford Courant*, August 27, 2012, available at [http://articles.courant.com/2012-08-27/news/hc-storm-insurance-coverage-20120827\\_1\\_hurricane-deductibles-higher-deductibles-standard-homeowners](http://articles.courant.com/2012-08-27/news/hc-storm-insurance-coverage-20120827_1_hurricane-deductibles-higher-deductibles-standard-homeowners)

agree that this is a concern. Insurers recognize that there is a high level of desire following a disaster for public officials to obtain information about the effects of the event, and that this includes insurer claim information. But it is true that responding to data requests requires resources in the form of employee time spent, and that they come at the precise time when the necessary people and systems are devoted to claims processing. So we urge regulators to recognize this challenge when they formulate data requests.

Particularly for insurers that write in more than one state affected by a catastrophe, such requests are most difficult when they are ad hoc and inconsistent among states. We recognize that regulators in many states have worked to enhance consistency; we commend those efforts and recommend that more be done in this area. There is similarly a need for predictability and consistency among states in regard to any directives that may be issued following a catastrophe.

Of great concern to NAMIC members are state actions regarding the applicability of percentage deductibles such as hurricane, named storm, and wind deductibles. These deductibles are important risk management tools developed by insurers to manage their exposure to catastrophic risk. They affect pricing, reinsurance, tolerable concentration of risk, and ultimately solvency. They are used to keep coverage available and affordable and they help keep coastal insurance markets competitive. But in order for deductibles to serve their intended purposes, insurers need to know they will be able to rely on such deductibles in the event of a triggering catastrophe.

With Hurricanes Irene and Sandy, we have seen repeated situations in which commissioners, governors and other public officials have issued press releases, advisories or other statements regarding the applicability – or rather inapplicability – of deductibles. While we recognize the intent behind such declarations is to assist consumers, they raise a number of problems.

In some cases, such declarations have been overly broad, seemingly applying to a range of deductibles rather than a specific kind. In at least one case, a released statement essentially pressured insurers to waive deductibles even if they had been triggered by the storm. Even in cases where the statements were accurate, their very issuance carries the implication that application of a deductible is a matter of discretionary public action rather than a function of contractual terms. The result of this activity raises questions about the viability of percentage deductibles as a catastrophe risk-management tool. In NAMIC's view, whether deductibles are applicable in a given instance should be determined solely by the contractual language in an insurance policy. Their applicability should not be subject to political pressures.

That in some situations the declarations were consistent with the terms of statutory or regulatory restrictions on deductible application does not resolve our concerns about the applicability of deductibles. These storms were major events; they were precisely the kinds of events for which insurers intended to reduce their exposure through the use of percentage deductibles. In order for deductibles to serve their purpose, it may be that statutory and regulatory restrictions will have to be revisited.

There are additional concerns regarding the way declarations regarding applicability of deductibles have been handled, in that some statements have caused confusion and/or carried implications suggesting that insurers would be doing something morally wrong if they applied a

deductible. We believe that, following a catastrophe, public officials should look to the property and casualty insurance industry as a vital partner in helping to respond to the event. They should view the industry as working in common purpose to assist consumers rather than using public channels to portray the industry in a negative light.

### **Conclusion**

NAMIC members take seriously their role in responding to insureds' needs following a catastrophe. They devote resources to processing claims as quickly as possible. Operating in a competitive marketplace, they constantly evaluate processes with an eye toward innovation and enhancement. We believe that every indication suggests that property and casualty insurers perform well in responding to catastrophes, but we also recognize that there is potential for improvement. We look forward to the exchange of ideas resulting from this forum.

We further believe that there is a need for changes in the ways public officials sometimes respond to insurance issues following a catastrophe. We believe that the industry and government should view themselves as working together following a catastrophe to respond to the needs of consumers.



# Written Comments





# CONSUMER SERVICES

*Department of Financial Services*

TO: Mike Chaney, Chair,  
NAIC Property and Casualty Insurance Committee

FROM: Tasha Carter, Director,  
Florida Department of Financial Services' Division of Consumer Services

DATE: November 15, 2012

SUBJECT: **Comments Regarding Post-Catastrophe Claim Settlement Practices**

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Much of our nation has been touched by some kind of natural disaster in recent years, making a review of post-catastrophe claim settlement practices a very timely and urgent matter. In Florida, we have experienced a range of natural disasters from hurricanes to fires, and the Florida Department of Financial Services, overseen by Florida's Chief Financial Officer Jeff Atwater, has a response plan that gets insurance consumer specialists into hard-hit areas quickly to assist disaster victims with claim filing. We are among the earliest witnesses – just behind first responders – and we see the initial shock and impact as well as the dismay and anger of desperate consumers frustrated with the claims process.

Following are our observations and suggestions relating to insurance companies:

### ***Additional Living Expense (ALE)***

**Issue:** Immediately following a disaster, many homeowners are displaced and need immediate financial assistance. However, the timeframes within which the first ALE payment is disbursed often varies and can be prolonged due to the number of claims filed.

**Recommendation:** Require insurance companies to advance the first ALE payment to the policyholder without requiring the submission of receipts and other documentation; however, the policyholder would be required to submit receipts for expenditures and other items in order to receive future ALE payments. This will help in alleviating some of the stress the policyholder is experiencing and provide them with faster relief. The first ALE advance can be deducted from future claims payments.

### ***Denial of Claim***

**Issue:** Insurance companies can deny a claim based on material misrepresentation. However, it is becoming more prevalent for some companies to wait until a major claim is filed to deny the



claim based upon misrepresentation on the original application. The denial can occur years after the original application was filed and after thousands of dollars of premium have been paid. This puts the policyholder under the false pretense that their home is covered and their family protected.

**Recommendation:** Insurance companies should be required to review all applications for material misrepresentation during an initial review period and follow appropriate cancellation procedures, if necessary. They should also make every effort to ensure they have correct policyholder contact information so that Proof of Loss forms, checks and necessary documentation reaches the policyholder.

### ***Adjusters***

**Issue:** Due to the high volume of claims typically filed following a disaster, insurance companies often must hire additional adjusters. In Florida, we have seen adjusters with no residential adjusting experience recruited to work on behalf of insurance companies, which can create complications that prolong the claims process for the policyholder.

**Recommendation:** All adjusters that are hired to adjust residential claims must have residential adjusting experience.

**Issue:** Adjusters have the option to work in multiple states and for multiple insurance companies at any given time. Florida has seen situations in which adjusters have adjusted claims on behalf of one insurance company and then decided to leave to go work for another insurance company without providing the first insurance company the documentation related to the claims they had been working on. This results in stalled claims and a prolonged process.

**Recommendation:** Require adjusters to submit their current adjusting documentation for all claims worked prior to leaving the area.

**Issue:** Insurance companies and/or adjusters can lose documentation submitted by the homeowner to validate their claim.

**Recommendation:** Improve processes to reduce the loss of policyholder documentation. Nothing is more frustrating to a policyholder than hearing that documentation they submitted, such as pictures, has been lost or misplaced and has to be resubmitted.

### ***Claims Toll-Free Helpline***

**Issue:** Insurance companies may not have enough staff to handle the increased call volume resulting from a large disaster.

**Recommendation:** Insurance companies should plan to increase the number of toll-free claims helpline staff and helpline hours to accommodate the increased number of calls that will be received as a result of a disaster.

### ***Company Policies and Procedures***

**Issue:** Insurance company policies and procedures should be clear and be disseminated to all staff and middle management for better tracking of responses to policyholders and state regulatory authorities.

**Recommendation:** Ensure that communication within the company is clear concerning claims and settlement issues so that senior management and front line call staff are fully informed.

### ***Claims Settlement Process***

**Issue:** Claims need to be settled as quickly as possible.

**Recommendation:** Companies must have clear processes to move disputed claims to either mediation or the appraisal process.

Following are observations and recommendations for what states may be able to do to better assist their insurance consumers in the aftermath of a natural disaster:

### ***Mandate Insurer Response***

**Issue:** Disaster victims with insurance coverage need to be able to make quick contact with their insurance company.

**Recommendation:** States should consider establishing “insurance villages” and ensure that companies with a significant policy base in the affected area send representation.

### ***Insurance Company Contacts***

**Issue:** States need management contact information for all involved insurance companies.

**Recommendation:** Require maintenance of current contact information for managers of insurance companies transacting insurance in the state.

### ***Mediation***

**Issue:** States must be prepared to process complaints and requests for mediation.

**Recommendation:** Ensure appropriate staff and resource levels to handle influx of consumer requests.

Our Department offers tips and resources year-round, and aggressively pre-hurricane season, to help consumers protect their homes and families. The following tips for consumers can make for a much smoother claims process and perhaps can be promoted as part of a consumer education awareness campaign by the NAIC:

### ***Contents Inventory***

**Issue:** Policyholders fail to complete a documented content inventory prior to a disaster. This creates a long and laborious claims process and typically results in an inaccurate accounting of items which in turn may result in lower claim payments for the policyholder.

**Recommendation:** Consumers must complete a room-by-room content inventory annually to ensure complete and accurate information is provided to the insurance company following a disaster. The more detailed documentation that is provided during the claims process, the faster the claim can be processed.

### ***Policy Information***

**Issue:** After a disaster, policyholders typically do not have a copy of their policy, declarations page or even their policy number, and further do not know the terms of their policy.

**Recommendation:** Policyholders should perform an annual review of the type and amount of coverage they have to ensure they are adequately protected in the event of a loss. Policyholders should also maintain their insurance policies, inventory records, agent or company telephone numbers and other important documents in a safe place that is easily accessible after a disaster.

### ***Understanding the Deductible for a Disaster***

**Issue:** Policyholders must be aware of the deductible amount when filing a post-disaster claim.

**Recommendation:** Policyholders must be educated on the different deductibles that can exist in a policy. In Florida, most homeowners' policies include a larger deductible for hurricane damage and a smaller deductible for other damage.

### ***Additional Living Expenses***

**Issue:** Most homeowners' policies pay ALE "as earned," meaning that the company will reimburse the policyholder only after expenses have been incurred for food, clothing and shelter and often only when a disaster makes the home uninhabitable. In some cases, however, a policyholder may be ordered to evacuate even though their home is not damaged, and different policies will cover these circumstances differently.

**Recommendation:** Consumers must keep all receipts during this period and know whether lodging and meals are covered if they must evacuate even though no damage has occurred to their property. They also must know whether any deductible or coverage limits apply.

### ***Secure Documents***

**Issue:** Documenting policies and financial records before a disaster is critical, but having access to them after the storm is even more important.

**Recommendation:** Policyholders, particularly business owners, should have access to back-up copies of important documents. Electronic and hard copies of important records should be stored in multiple sites, even in another city or state, in the event of extensive or widespread damage.

Our nation is struggling through a challenging economic recovery. Every dollar spent on insurance must count, and policyholders must be able to count on their insurance coverage. Please let me know if I can provide any further information to assist in your review of these important considerations.



## LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON  
COMMISSIONER

### Comments for the Public Hearing on Catastrophe Issues

The recent regulatory responses to Hurricane Sandy and subsequent storms in the mid-Atlantic and Northeast demonstrate the wealth of catastrophe experience that NAIC members have developed and shared over the last several years. Louisiana has in recent years had considerable experience with catastrophe events from which many lessons were learned affecting the business and regulation of insurance. Louisiana learned a great deal about consumer-friendly, post-disaster, claim-settlement practices and the implementation of regulatory actions in response to a natural catastrophe affecting large areas and population centers. Louisiana learned some through experience, but more importantly it received assistance from Florida, which had in prior years suffered successive hurricanes and already developed regulatory responses to the issues faced by Louisiana. Louisiana has in turn shared its accumulated knowledge with other states in recent years. It is time to formalize the process of sharing this information and preparing guidelines or models for regulatory response to catastrophe situations.

Since hurricanes Katrina and Rita in 2005 and subsequent disasters, Louisiana has enacted statutory authority and prepared regulatory actions to be effective upon the declaration of a disaster. They address a variety of consumer issues including claims practices and regulatory actions that account for the extraordinary burdens imposed by wide area catastrophes. In the area of consumer-friendly claims practices, we have required companies to provide a complete copy of the policy to the policyholder who may have lost it in the catastrophe. Such things seem unimportant but to a person trying to determine his legal and contractual rights in a time of crisis they are of paramount importance. In the area of regulatory actions, we have, for example, undertaken to expedite the licensing of adjusters for catastrophe claims and to extend the very short legal time limits on the adjustment and settlement of property and casualty claims.

## Comments for the Public Hearing on Catastrophe Issues

Given the large body knowledge manifested in the statutes, regulations, bulletins, etc. enacted and published by the states to date, a best first step would be to compile those resources for distribution and review by state insurance departments and interested parties. From there a list of practices could be derived and commented upon to determine those that are best or recommended and have a general application. From such a list the more contentious issues could receive more focus in the form of whitepapers and those issues that are not contentious could be the basis of the development of guidelines or models as deemed appropriate by the NAIC.

Louisiana would welcome the opportunity to share with other states in a more structured forum its lessons learned and to learn from them lessons derived from their more recent experiences.