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Standard Guide for Laboratory Accreditation Systems[1]

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INTRODUCTION

Accreditation is a term frequently used in recognizing the technical capability of a laboratory. In general, accreditation is conferred on a laboratory which has undergone successful evaluation and which continues to conform to the requirements and criteria of an accreditor, for the areas of operation covered by the accreditation. This does not imply that only accredited laboratories are technically competent since not all laboratories seek or require accreditation. For that matter, accreditation may not be available because no accreditor exists in the area of operation of some laboratories. This guide identifies important features of laboratory accreditation systems where such exist, are under development, or are being contemplated. Laboratory accreditation systems should not be confused with product certification systems.

1. Scope

1.1 This guide identifies important features of systems which accredit testing laboratories, inspection bodies, or other organizations involved in testing, measuring, inspecting, and calibrating activities. For the sake of brevity, the term "laboratory" is used in this guide to represent testing laboratories, inspection bodies, or other organizations involved in testing, measuring, inspecting and calibrating activities.

1.2 This guide provides guidelines for the qualifications and selection of assessors, the conduct of on-site assessments, the implementation of proficiency testing, and the evaluation of laboratories leading to accreditation.

1.3 *This standard may involve hazardous materials, operations, and equipment. This standard does not purport to address all of the safety problems associated with its use. It is the responsibility of whoever uses this standard to consult and establish appropriate safety and health practices and determine the applicability of regulatory limitations prior to use.*

2. Applicable Document

2.1 E 548 Practice for Preparation of Criteria for Use in the Evaluation of Testing Laboratories and Inspection Bodies[2]

3. Significance and Use

3.1 This guide is applicable where the systematic assessment of the competence of a laboratory by a user or other party takes place, even in situations where no formal accreditation is awarded. This guide is not intended to be used in direct contract agreements between accrediting bodies, assessors, or accredited laboratories.

3.2 This guide is written in general terms and therefore some sections may not be applicable for specific circumstances. The document addresses assessment practices of major concern for most situations.

4. Laboratory Accreditation System Features

4.1 A laboratory accreditation system should:

4.1.1 Have documentation defining the rules

[1] This guide is under the jurisdiction of ASTM Committee E-36 on Criteria for the Evaluation of Testing and Inspection on Agencies and is the direct responsibility of Subcommittee E 36.10 on Generic Criteria.

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[2] *Annual Book of ASTM Standards*, Vol 14.02.

and operations of the accreditation system including the requirements of any contractual arrangements between the accrediting body and the accredited laboratories, and for any assessor retained by the accrediting body on a contract basis.

4.1.2 Publish the accreditation criteria, evaluation procedures, and associated fees, if any, in a manner appropriate for the type of laboratories involved.

4.1.3 Have a policy and procedures to prevent accreditation from being misrepresented as product certification.

4.1.4 Specify the scope of accreditation in terms of specific tests, types of tests, products, or specifically delineated functions as defined by recognized standards.

4.1.5 Accredit laboratories on the basis of evaluation against published specific criteria having an adequate degree of specificity to relevant specific tests, specific types of tests, or specific products, as appropriate. The specific criteria should be formulated by organizations or persons possessing the necessary technical competence in the relevant testing.

4.1.6 Have documented evaluation procedures for initial and announced or unannounced follow-up assessments, with a means for ensuring the correction of identified deficiencies.

4.1.7 Assess laboratories through an on-site review using assessors, singly or in teams, who have expertise in the area of testing for which accreditation is sought. Assessment should include a written report from the assessors.

4.1.8 Assess laboratories through periodic proficiency testing, when feasible, in addition to on-site review.

4.1.9 Publish, as appropriate, a directory of laboratories it accredits showing the specific scope of each accreditation.

4.1.10 Have documented procedures for revoking accreditation from laboratories failing to comply with accreditation criteria.

4.1.11 Have impartial or independent appeals procedures to resolve disputes associated with accreditation, including policies and procedures designed to minimize conflicts of interest and assure that accreditation is based on recognized competence without bias.

4.1.12 Have a procedure that solicits and encourages feedback from participants in order to promote uniform implementation of these guidelines among accredited laboratories.

5. Assessors

5.1 *Qualifications of Assessors:*

5.1.1 Assessors should be technically competent to assess the operations of a laboratory in those specific tests, types of tests, or products, or other specifically delineated functions for which accreditation is sought. They should be able to communicate effectively, both in writing and orally, and have the combination of qualifications and experience necessary to enable them to function effectively as members of an assessing team, as lead assessors, or independently, as applicable.

5.1.2 Assessors should have undergone instruction to the extent necessary to ensure their competence in assessment techniques. As appropriate, the instructions should cover the rules, operation, and criteria of the accrediting body and procedures for questioning staff, examining and evaluating the laboratory, and reporting the results.

5.2. *Records of Assessors*—Accrediting bodies should maintain up-to-date records on the qualifications of assessors such as:

5.2.1 Name,

5.2.2 Educational qualifications and professional status,

5.2.3 Experience as assessor,

5.2.4 Work experience,

5.2.5 For assessors other than employees of the accrediting body, and position held and the organization in which employed, and

5.2.6 Date of most recent updating of record.

5.3 *Acceptability of Assessors:*

5.3.1 The accrediting body should have policy and procedures for minimizing conflict of interest in the assignment of assessors. Laboratories undergoing assessment should be given the right to appeal assigned assessors and request mutually agreeable alternates. For assessors other than employees of the accrediting body, the contractual arrangements between the accrediting body and such assessors should be defined.

5.3.2 The accrediting body (together with organizations providing assessors and the assessors themselves as appropriate) should review the qualifications of each assessor on a continuing basis and, in particular, prior to any given assessment exercise. Organizations providing assessors or the assessors themselves are responsible for supplying evidence of acceptability to the accrediting body.

5.3.2.1 Based on its own evaluation, the ac-

crediting body may extend or cancel the acceptability of an assessor, or require retraining or requalifications. Such evaluation shall be documented.

6. On-Site Assessments

6.1 *Definition and Purpose*—On-site assessments consist of visits to a laboratory by one or more specialist assessors to provide an accrediting body with relevant information concerning the capability of the laboratory to meet established criteria for accreditation.

6.2 *Assessors Responsibility*—An assessor should:

6.2.1 Assess (by interview, by observing tests being performed or arrangement of practical audit tests) the knowledge and technical competence of staff in the area of accreditation.

6.2.2 Examine critical aspects of the laboratory's equipment, facilities, calibrations, test procedures, sample handling and control, data preparation and reporting, and quality practices related to the specific test, calibrations, measurements, or inspections for which the laboratory seeks accreditation, and

6.2.3 Provide the accrediting body with pertinent information concerning the organization and operation of the laboratory which will enable the accrediting body to evaluate compliance with defined accreditation criteria.

6.3 *Preparing for an Assessment*—Before an on-site assessment is conducted the accrediting body should prepare a briefing document or checklist as a guide for assessors. It should typically include the information as supplied by the laboratory on various aspects of its operations, including as applicable:

6.3.1 Name and address of the laboratory, and the name of the key managers and supervisors.

6.3.2 List of the tests, types of tests, products, or specifically delineated functions as defined by recognized standards for which the laboratory is seeking accreditation.

6.3.3 Staff structure of the laboratory and relevant information on qualifications and experience of the supervisory staff,

6.3.4 General description of the laboratory's facilities for testing and related activities.

6.3.5 General information on the laboratory's quality control practices.

6.3.6 Full details of the test methods (test plans) used by the laboratory to perform the tests listed in 6.3.2.

6.3.7 List of the major items of equipment used to perform the tests listed in 6.3.2 together with details on the calibration and standardization practices used.

6.3.8 Procedures used by the laboratory to evaluate and monitor the quality of its work.

6.3.9 Procedures used by the laboratory for sampling, identifying, handling, and tracking test specimens.

6.3.10 Procedures used by the laboratory for recording and retaining original test observations and calculations and the methods used for checking calculation and data transfer, and

6.3.11 Format used by the laboratory for reporting test results.

6.4 *Conducting an On-Site Assessment:*

6.4.1 It is usually helpful to begin an on-site assessment with an initial briefing interview with the involved senior staff of the laboratory and all members of the assessment team. This briefing and information exchange is to inform the laboratory's senior management of the team's objectives and methods of operation.

6.4.2 To provide uniformity, the assessment should be conducted with the aid of worksheets. The worksheets may take one of the following forms:

6.4.2.1 Brief list to serve as a reminder of the items to be covered during an assessment and over which the assessor is afforded great latitude in technical judgment,

6.4.2.2 Comprehensive checklist upon which the assessor verifies the presence or absence of some specific attribute, and

6.4.2.3 Checklists on which the assessor is expected to evaluate the laboratory's degree of compliance on the basis of a qualitative ranking.

6.4.3 The on-site assessment should be organized to cover the specific criteria of the accrediting body, and any other established requirements for accreditation. In general it should include a thorough examination of the laboratory's mode of operation from the time of sample receipt to a final test report. Equipment and records should be examined. Staff should be interviewed in order to gain a general assessment of their competency. If possible critical portions of test operations should be observed. Supervisors and managers should be interviewed regarding quality control practices. If inconsistencies between records, observations, and responses are detected it should

be determined whether such inconsistencies are symptomatic of the laboratory's operation.

6.4.4 It is valuable to conclude the on-site assessment with a briefing conference with the involved senior staff of the laboratory and all members of the assessment team. The assessor's preliminary report, notes, or worksheets should be reviewed and any observed and uncorrected deficiencies discussed. The assessor should leave with the laboratory a copy his preliminary report, notes, or worksheets if so designed, which will be used as the basis for the report he plans to file with the accrediting body.

6.5 *Assessor's Reports*—As soon as possible after an assessment the assessors should prepare and forward to the accrediting body completed worksheets and a written report summarizing the on-site visit. The assessor's report should:

6.5.1 Identify observed and uncorrected deficiencies relating to the accreditation criteria,

6.5.2 Identify the results of observed proficiency testing, if any, and

6.5.3 Give recommendations on specific tests or testing areas for which accreditation should or should not be granted, together with supporting reasons, for only those items which have been or should have been discussed with laboratory personnel as set forth in 6.4.4.

6.6 *Surveillance and Reassessments:*

6.6.1 After a laboratory is accredited, full or partial reassessments should be conducted at periodic intervals to ensure that the required standards of management and operation are maintained. The frequency of reassessment and whether such visits are announced or unannounced are a matter of policy to be established by the accrediting body.

6.6.2 Partial reassessments should be conducted whenever major changes occur in a laboratory which may affect the reliability of its services. Changes such as movement of involved senior staff, the location of the laboratory, the ownership of the laboratory, its functions, or the type and ranges of major equipment may be valid reasons for undertaking at least partial reassessment.

6.6.3 Further reassessments may be required if the laboratory seeks accreditation for additional tests.

7. Proficiency Testing

7.1 *Definition and Use of Proficiency Testing:*

7.1.1 Proficiency testing is a means of evaluating the performance of a laboratory through actual tests performed. Proficiency testing may be used to give relevant comparison data to augment other evaluations to determine the acceptability of a laboratory for accreditation, or may be used as a go or no go criteria for accreditation.

7.1.2 An accrediting body should make every effort to utilize proficiency testing as part of its evaluation procedures. However, good performance in a particular proficiency test only indicates the ability of a laboratory to obtain reliable results at a particular point in time under given conditions for those tests involved. Proficiency testing should be augmented by on-site assessment to ensure that the same operating practices and quality assurances are applied under routine testing conditions.

7.1.3 Proficiency testing may not be practical in all cases because of cost, lack of uniform or characterized test specimens, statistical soundness, or the inability to transport test specimens. The importance of proficiency test results in the accreditation of a laboratory should be judged by the accrediting body.

7.2 *Types of Proficiency Testing:*

7.2.1 Several types of proficiency testing procedures have been used depending on the nature of the product, the test method, and the number of participants. Some of the procedures are:

7.2.1.1 *Reference Laboratory*—A basic reference laboratory, such as national standards laboratory, provides an audit package or sample which has been carefully measured. Such audit packages may be "radial," tailored to a particular laboratory, or "circular" with an audit package going to a number of laboratories, simultaneously or in succession. This type of proficiency testing is typically used in the operation of calibration programs.

7.2.1.2 *Group of Reference Laboratories*—When no single laboratory has national recognition for setting a national standard, the result from a group of laboratories may be used.

7.2.1.3 *Participant Laboratories*—If there is a sufficient number of participating laboratories the test results of all participants may be pooled to establish a target result for individual participants. In such cases it is important that pooled test results include only test data from laboratories known to follow the established test method.

7.2.1.4 *Split Sample*—This procedure makes use of samples of products which are routinely

tested. The sample, assumed to be homogeneous, is split into two parts, with the laboratory testing one part and a reference laboratory testing the other part. Typically, the reference laboratory tests its portion of the sample only occasionally.

7.2.1.5 *Intra Laboratory Proficiency*—Occasionally, split sample testing arrangements are used in establishing control charts at a laboratory. These charts are designed as an internal quality control which allows the laboratory to check its output frequently. Such measurements might be considered proficiency testing if an accrediting body requires the results to be compared occasionally with the performance of other laboratories.

7.3 *Proficiency Testing System Design.*

7.3.1 *Procedures and Samples*—The type of proficiency program and the nature of the samples to be used should be explicitly identified by the accrediting body, bearing in mind the specific aims of the program and various other relevant considerations which may be technical, practical or economic.

7.3.2 *Selecting Samples for Test*—The characteristics of the samples to be tested should be known and stable to the degree required for the purpose of the test. Satisfactory procedures for randomizing samples, as appropriate, should be employed.

7.3.3 *Sample Handling*—Documented procedures for proper identification and safeguarding of the samples (such as environment and shock protection) during procurement and shipment to the laboratories should be specified and implemented. If the samples must be returned to the accrediting body, requirements for this should also be specified.

7.3.4 *Sample Preparation and Test*—Specific directions should be given on how the laboratory is to treat the sample once it is received (such specification might well include environmental conditioning, and sample preparation for the actual test). The sample should be clearly identified and the test procedure to be used clearly specified to the laboratory.

7.3.5 *Preparation and Communication of Results*—Directions should be clearly given to the laboratory on the method of presentation of test data, including the parameters to be recorded and the layout required. Ideally, standardized data sheets for conveying results should be provided.

7.3.6 *Analysis and Evaluation of Results*—The accrediting body should specify the procedures it will use to analyze, compare and evaluate the test data. Such procedures should be based on accepted statistical principles. The detailed analysis may depend on the number of participants with more rigorous statistical procedures employed as the number of laboratories participating increases.

7.3.7 *Action Based on Results*—The accrediting body should have written procedures clearly defining its response to the different possible outcomes of a proficiency test. Proficiency test results are typically used as just one of several factors in evaluating the performance of a testing laboratory. Usually, such test results must be within a specific target range before a laboratory can be accredited. Where unsatisfactory performance is indicated, the accrediting body may identify particular areas of weakness in a laboratory's operations and suggest remedial action.

7.3.8 *Reporting Results*—The accrediting body should have a policy for reporting the results of proficiency testing. In general, laboratories want to receive feedback of their performance as soon as possible to determine how close their measurements were to target values and how well they performed compared to the group. Several methods exist for providing feedback. These include individual test reports prepared for each participant and issued after each test, or a collective overall report showing the performance of all participants. In the latter format, to retain anonymity, each laboratory is generally identified by a code number.

8. Questionnaires

8.1 *Definition and Use of Questionnaires:*

8.1.1 Questionnaires may be used for gathering information about a laboratory for the purpose of evaluation. A questionnaire may be part of an application which a laboratory completes when accreditation is requested, or it may be a stand-alone document especially tailored for the circumstances by the accrediting body once an application has been received.

8.1.2 The aim of questionnaires should be to elicit sufficient information upon which evaluation may be made without causing undue burden for written materials of questionable value. They should be designed so that short answers satisfy most questions.

8.1.3 Questionnaires alone can never serve as a replacement for an assessment conducted on-site. In order to improve efficiency, the information gathered from questionnaires should be used to prepare assessors for on-site visits.

9. Evaluation of Laboratories

9.1 *Technical Peer Evaluation:*

9.1.1 An accrediting body should use technical peers to evaluate the relevant information obtained which relates to a laboratory's performance. A technical peer is a person with extensive experience in the field of testing, in testing procedures, or in some other technical skill pertinent to the evaluation.

9.1.2 Technical peers may be used singularly or as part of a committee or team to review information from the following sources:

9.1.2.1 The assessor(s) formal report of the on-site visit to the laboratory,

9.1.2.2 Results of proficiency testing,

9.1.2.3 The application which has been completed by the laboratory and any other related information,

9.1.2.4 Information from questionnaires, and

9.1.2.5 Communication from the laboratory which describes steps taken to correct deficiencies which the assessor identified during the on-site visit.

NOTE—At this stage, the deficiencies identified by the assessor do not necessarily represent the authoritative opinion of the accrediting body.

9.1.3 If a technical committee is used it may be formed in various ways depending on the needs and policy of the accreditation system. Two possible committee configurations are:

9.1.3.1 A formal assembly of technical peers named to serve the accrediting body for a specified period of time, with formal rules and structure, or

9.1.3.2 An informal assembly of technical peers who are brought together on an ad hoc basis by the accrediting body to review the information and make recommendations.

9.1.4 Normally, a staff person acts as secretary to the committee, providing copies of the information, secretarial services, and the like. Members of the committee are often technical peers who are assessors for the accrediting body. Some committees may be divided into subcommittees to address particular technical specialties.

9.1.5 The recommendation of the technical committee with a summary of technical findings is the basis upon which the accreditation decision is taken. Assessor(s) who have visited the laboratory as part of the assessing team are not normally included as members of the technical committee reviewing qualifications of that laboratory, although the assessor(s) may be asked to respond to questions of the technical committee to provide clarifying information.

9.1.6 When a technical committee includes members other than full time employees of the accrediting body, the accrediting body should have and implement rigorous procedures to safeguard the confidentiality and anonymity of the laboratory being evaluated.

10. Deciding on Accreditation

10.1 *Decision Mechanisms*—There are two ways in which the decision to accredit a laboratory may be reached, both similar in character but different in participation:

10.1.1 *Management Council*—The accreditation system may establish a management council composed of senior executives (public or private sector) which is responsible for granting accreditation. The council reviews the evaluation provided by the technical peer evaluators and decides to grant or deny accreditation. Except in cases which may prove to be controversial or difficult a council chairman may be empowered to act on behalf of the council.

10.1.2 *Accrediting Body*—The accrediting body itself may review the evaluation and decide upon accreditation.

10.2 In each case, if the decision is to deny accreditation to a laboratory, the management council or accrediting body should formally advise the laboratory of the deficiencies which must be corrected before accreditation can be granted. In practice, most deficiencies have already been eliminated, based upon the informal guidance of the assessor during the on-site visit.

10.3 A verification should be requested from the laboratory in the form of a letter stating how the deficiencies have been eliminated. In those instances where a deficiency is particularly crucial to the performance of a test, a visit or other form of verification may be necessary.

10.4 An accreditation system should have an appeal mechanism for cases where accreditation is denied. The appeal mechanism may involve a complete reassessment by different assessors or

may consist of a formal review of all actions taken. Policies and procedures designed to minimize conflicts of interest and assure that accreditation is based on recognized competence without bias should be in place.

11. Awarding Accreditation

11.1 *Type of Documentation:*

11.1.1 When a decision is made to accredit a laboratory, a formal accreditation document such as a letter or certificate should be prepared, signed by the appropriate officer, and transmitted to the laboratory.

11.1.2 The accreditation document should identify the laboratory by name and address and indicate the scope of the accreditation including a complete list of the test methods or other descriptors which specify precisely the testing or services for which accreditation is granted, as appropriate.

12. Notification of Accreditation

12.1 *Directory:*

12.1.1 If the accrediting body publishes a directory of accredited laboratories, the directory should identify each laboratory along with the terms of its accreditation expressed by a complete list of test methods or other descriptors which specify precisely the testing or services for which accreditation is granted.

12.1.2 The accrediting body should also specify to its accredited laboratories the limitations imposed on how they may publicize their accredited status, use their accreditation documents, and display any existing logo.

13. Significance of Accreditation

13.1 *Accreditation System Information*—In order for users of accredited laboratories to understand and appreciate the significance of accreditation, the accreditation body should make the following information about itself available.

13.1.1 Title of the accreditation system.

13.1.2 Authority under which the system was established (governmental legislation, private sector initiative and the like) whether mandatory or voluntary, the data established and the source of funding for its operation.

13.1.3 Extent, nature, and limits of the system including the tests and types of tests for which it confers accreditation.

13.1.4 Publications of documentation concerning the accreditation system including promotional materials and directories of the laboratories it has accredited.

13.1.5 Fees charged to participants or users of the system.

13.1.6 Requirements, restrictions or limitations on the use of the system logo, if any, by accredited laboratories and users of laboratory services.

13.1.7 Criteria and procedures used for accrediting laboratories.

13.1.8 Assessment techniques employed including the rigor and frequency of assessment (questionnaires, announced or unannounced on-site reviews, random visits, proficiency testing, and the like).

13.1.9 Source and nature of assessors used, the authority that grants or recommends accreditation, and the duration for which accreditation is granted.

13.1.10 Appeal procedures available to laboratories for resolution of disputes associated with accreditation, and

13.1.11 Primary contact (name, address and phone number) who can process an application or in other ways respond knowledgeably to inquiries about the accreditation system.

Chapter 296-402

ELECTRICAL TESTING LABORATORY ACCREDITATION

WAC

WAC 296-402-010 FOREWORD. This chapter is promulgated in accordance with the provisions of chapter 19.28 RCW which covers electricians and electrical installations.

To qualify for certification as an approved electrical products testing laboratory, the criteria of this chapter shall be complied with.

WAC 296-402-020 PURPOSE AND SCOPE The purpose of this chapter is to provide recognition and accreditation of electrical products testing and certification laboratories for the state of Washington so the general consuming public can be assured that electrical products have been tested for safety and identified for their intended use.

Any electrical product, device, system, material or installation which is accepted, or classified, identified, or certified, or listed, or labeled by a Washington State accredited electrical products testing laboratory shall be deemed to have been successfully evaluated for safety.

WAC 296-402-030 DEFINITIONS. The definitions set forth in this section shall apply throughout this chapter.

(1) "ANSI" means American National Standards Institute.

(2) "Certified electrical product" means an electrical product that is certified under this chapter:

(a) To which a label, symbol, or other identifying mark of an approved testing laboratory has been attached to indicate that the manufacturer produced the product in compliance with appropriate standards or that the product performs in a specified manner.

(b) That is not decertified.

(3) "Certification mark" means a specified approved testing laboratory identification indicating that a certified electrical product has been manufactured in accordance with the requirements of appropriate standards or tested for specific end uses.

(4) "Certification program" means a specified set of testing, inspection, and quality assurance procedures, with appropriate implementing authority directed toward evaluating products for certification of compliance to the requirements of appropriate standards.

(5) "Department" means the department of labor and industries.

(6) "Labeled" means an electrical product to which a label, symbol, or other identifying mark of an approved laboratory is attached.

(7) "Laboratory operations control manual" means a document consisting of specified procedures and information for each test method responding to the application requirements of the product standard.

(8) "Quality control manual" means a document consisting of general guidelines for the quality control of the laboratory's method of operation. Specific information is provided for portions of individual test methods whenever specifics are needed to comply with the criteria or otherwise support the laboratory's operation.

WAC 296-402-040 ORGANIZATION. The laboratory shall be an independent, third-party testing and inspection organization with no organizational, managerial, or financial affiliation with manufacturers, suppliers, or vendors of products covered under its certification programs.

(1) The laboratory shall not be owned by manufacturers or vendors.

(2) The laboratory administration shall not be controlled by manufacturers or vendors.

(3) The laboratory shall be legally constituted and permitted to perform certification work.

(4) The laboratory shall not be engaged in the promotion or design of the product being evaluated, tested, or certified.

(5) The laboratory shall have sufficient diversity of clients or activity so that the loss or award of a specific contract regarding certification would not be a determinative factor in the financial well-being of the laboratory.

(6) The employment security status of the personnel of the laboratory shall be free of influence or control of manufacturers or vendors of products certified.

WAC 296-402-050 PROFESSIONAL AND ETHICAL BUSINESS PRACTICES. The laboratory shall be operated in accordance with generally accepted professional and ethical business practices and shall agree in writing that as a mimimum it will be its policy to:

(1) Perform the examinations, tests, evaluations and inspections required under the certification programs in accordance with the designated standards and procedures.

(2) Assure that reported values accurately reflect measured data.

(3) Limit work to that for which competence and capacity are available.

(4) Treat test data, records, and reports as proprietary information.

(5) Respond and attempt to resolve complaints contesting test results and certifications.

(6) Be capable of performing all examinations, tests, evaluations, and inspections for certification programs for which it is approved according to the latest effective version of applicable safety standards as adopted by rule, and require that all certified products produced after the effective date comply with such standards.

(7) Maintain an independent relationship between its clients, affiliates, or other organizations, so that the laboratory's capacity to render test reports and certifications objectively and without bias is not adversely affected.

(8) Notify the department within thirty calendar days should it become unable to conform to any of these criteria.

WAC 296-402-060 QUALITY CONTROL SYSTEM. the laboratory shall maintain a quality control system to help assure the accuracy and technical integrity of its work as follows:

(1) The laboratory's quality control system must include a quality control manual or a laboratory operations control manual containing written procedures and information in response to the applicable requirements of the product standard. The procedures and information may be explicitly contained in the manual or may be referenced so that their location in the laboratory is clearly identified. The written procedures and information must be adequate to guide a testing technician and inspector in conducting the tests and inspections in accordance with the test methods and procedures required for the certification programs for which accreditation is sought.

(2) The laboratory shall have a current copy of its quality control manual available in the laboratory for use by laboratory personnel and shall make the manual available to the department for review and audit.

WAC 296-402-070 PERSONNEL. The laboratory shall be staffed by competent personnel who shall have the necessary education, training, technical knowledge, and experience for their assigned functions to perform the tests, examinations, reevaluations, and inspections for certification programs for which accreditation is sought.

(1) There shall be a job description for each senior technical position category.

(2) The laboratory shall assure the competency of its staff through the observation and/or examination of each relevant staff member in the performance of tests, examinations, and inspections that each member is assigned to perform. The observations must be conducted at intervals not exceeding one year by one or more individuals judged qualified by the person who has technical responsibility for the operation.

(3) The laboratory shall make available the description of its training program for assuring that new or untrained staff will be able to perform tests and inspections properly and uniformly to the requisite degree of precision and accuracy.

(4) The laboratory shall maintain records, including dates of the observation or examination of performance of personnel. Information on the relevant qualifications, training, and experience of the technical staff shall be maintained by the laboratory and shall be furnished to the department on request.

WAC 296-402-080 CALIBRATION — VERIFICATION AND MAINTENANCE OF FACILITIES AND EQUIPMENT. The laboratory shall provide evidence of the calibration, verification, and maintenance of the facilities and equipment specified for each test method for certification programs for which accreditation is sought by means of the following:

(1) A description of the procedures used in calibrating, verifying, and maintaining the test equipment and facilities, including as applicable:

(a) Calibration and vertification equipment or services used.

(b) Reference standards and materials used.

(c) Measurement assurance, corraborative reference, or other programs in which the laboratory participates.

(d) Specified maintenance practices.

(2) Calibration and verification records, including as applicable:

(a) Equipment description or name.

(b) Name of manufacturer.

(c) Model, style, and serial number, or other identification.

(d) Equipment variables subject to calibration and verification.

(e) Statement of the instrument's allowable error and tolerances of readings.

(f) Calibration or verification schedule (intervals).

(g) Dates and results of last calibrations or verifications and schedule of future calibrations or verifications.

(h) Name of laboratory person or outside contractor providing the calibration or verification services.

(i) Traceability to National Bureau of Standards or other standard reference authority as required.

WAC 296-402-090 PLANS FOR CERTIFICATION PROGRAMS. The laboratory shall maintain plans for its certification programs for which accrediatation is sought which shall include, as applicable, instructions for:

(1) Equipment maintenance and verificaiton checks.

(2) Sample selection.

(3) Data collection, analysis, and reporting.

(4) Quality control checks and audits.

WAC 296-402-100 RECORDS. The laboratory shall maintain records and prepare reports of those testing, inspection, and certification activities associated with each program for which approval is sought. The laboratory shall make available to the department, upon request, a typical completed test or inspection report with the name of the client and source of any product deleted. Test and inspection reports shall contain, as applicable:

(1) Name and address of the laboratory.

(2) Pertinent data and identification of tests or inspections.

(3) Name of client.

(4) Description and identification of the sample including, as necessary, where and how the sample was selected.

(5) An appropriate title.

(6) Identification of the test, inspection, or procedure as specified for the certification program.

(7) Known deviations, additions to, or exclusions from testing, inspection, and certification activities in order to be appropriate to new or innovative products not contemplated by the standard.

(8) Measurements, examinations, derived results, and identification of test anomalies.

(9) If necessary, a statement as to whether or not the results comply with the requirements of the standard.

(10) Signature of person(s) having responsibility for the report.

(11) Data generated during testing if not included in the test report, such as raw and data, calculations, tables, graphs, sketches, and photographs, shall be maintained.

(12) Sample control forms documenting the receipt, handling, storage, shipping, and testing of samples or a written description of the procedures and separate records that are maintained to control these operations.

(13) The laboratory shall have copies of applicable standards and other documents referred to or used in performing each test or inspection for product certification for which approval is sought.

(14) The laboratory shall maintain records of its quality control checks and audits for monitoring its test work associated with its certification programs, including:

(a) Records of products assurance (follow-up) test results.

(b) Records of detected errors and discrepancies and actions taken subsequent to such detection.

(15) The laboratory shall maintain a record of written complaints and disposition thereof.

(16) The laboratory shall retain records required by these criteria for a miminun of three years.

WAC 296-402-110 PRODUCT CERTIFICATION PROGRAM. (1) General. The testing laboratory shall be approved only to certify those products identified by the laboratory in its application and as authorized by the department. The certification program shall contain the procedures and authority to ensure that the certified product complies with the standards (requirements) established by the program.

(2) Electrical product safety standard used. The standard used as the basis of the certification program shall be a state approved product safety standard that is determined to provide an adequate level of safety or define an adequate level of safety performance.

(a) Generally, such standards shall:

(i) Be recognized in the United States as an electrical product safety standard.

(ii) Be compatible with and be maintained current with periodic revisions of applicable national codes and installation standards.

(iii) Be developed by a standards developing organization under a method providing for input and consideration of views of industry groups, experts, users, consumers, and governmental authorities, and others having broad experience in the electrical products safety field.

(b) All ANSI safety designated electrical product standards are deemed acceptable without further qualification.

(c) If a testing laboratory desires to use a published standard other than an ANSI standard, the department shall evaluate the proposed standard to determine that it provides an adequate level of safety. If there exists an ANSI standard, or other published standard meeting the criteria of paragraph (a) of this subsection which has been recognized by the department for use in certification programs, the laboratory shall identify and justify all differences between the proposed standard and such ANSI standard or other standard previously recognized by the department.

(d) Where there is no published standard meeting the above cited criteria for the equipment under consideration, the department shall evaluate the proposed standard to determine that it provides an adequate level of safety. The laboratory shall identify and justify the adequacy of the standard or other specifications used as a source of requirements.

(e)The department shall review proposed standards to determine that they provide an adequate level of safety and shall present a recommendation concerning each proposed standard to the electrical advisory board at a regular or special board meetng for the board's approval.

(3) Evaluation of components. Components of certified products shall be evaluated for compliance with standards applicable to such components or found to be suitable for use in the product as stated in the end product standard.

(4) Certification agreement. Measures, such as the following, to provide for manufacturer compliance with the provisions of the product standard and laboratory control of the use of the certification mark shall be embodied in anagreement between the manufacturer and the testing laboratory:

(a) Require the manufacturer to provide such information and assistance as needed by the testing laboratory to conduct the necessary product conformity and production assurance evaluation.

(b) Require the manufacturer to provide the testing laboratory's representative access during working hours to the factory for inspection and audit activities without prior notice.

(c) Restrict the manufacturer to application of certification marks only to products that comply with requirements of the product standard.

(d) Secure the manufacturer's agreement to the publication of notice by the testing laboratory for any product already available in the marketplace that does not meet the safety standard.

(e) Whenever the standard covering the product is revised, require reevaluation of products as a condition of continued use of the certification mark.

(f) Provide for notification by the laboratory of the manufacturer's personnel responsible for and authorized to institute product recall in the case of a hazard.

(g) Provide for control of certification marks (or labels) by the testing laboratory.

(h) Require that the testing laboratory provide to the manufacturer a report of original; product evaluation, which documents by test results and other data, when conformity with the applicable product standard is achieved.

(i) Require the manufacturer to provide the identification of the manufacturer or vendor of the product, and, if the product is produced in more than one location, the place of manufacture of the product.

(5) Identification fo certified products. Certified products shall be labeled or marked with the certification mark of the approved testing laboratory.

(a) The certification mark shall:

(i) Be owned by the testing laboratory and be registered as a certification mark with the United States Patent and Trademark Office.

(ii) Not be readily transferable from one product to another.

(iii) Be directly applied to each unit of production in the form of labels or markings suitable for the environment and use of the product, except where the physical size of the unit does not permit, in which case markings may then be attached to the smallest package in which the unit is marketed.

(iv) Include the name or other appropriate identification of the testing laboratory.

(v) Include the product category where such is not completely obvious.

(6) Directory (list) of certified products. The testing laboratory shall publish annually a products directory to identify products that are authorized to bear the laboratory's certification mark (label). The products directory shall briefly describe the program, the products covered, the name of the manufcturer or vendor of the certified products, and the identification of the published standards or the compiled requirements on

which the program is based. The products directory shall be available to the public. Supplemental up-to-date information shall be publicly available at the office of the testing laboratory at any time during normal business hours.

(7) Original conformance (engineering) evaluation. Prior to authorizing the use of a certification mark on a product, the testing laboratory shall:

(a) Determine by examination and/or tests that representative samples of th product comply with the requirements (standards). Components of certified products shall also be required to comply with the safety standards (requirements) applicable to such components or found to be suitable for use as stated in the end product standard. Evaluation of the product design shall be made on representative production samples or on prototype product samples with subsequent verification that factory productions are the same as the prototype.

(b) Determine that the manufacturer has the necessary facilities, test equipment, and control procedures to ensure that continuing production of the product complies with the requirements.

WAC 296-402-120 PRODUCT ASSURANCE (FOLLOW-UP) ACTIVITIES. (1) General. Concurrent with and subsequent to authorizing the manufacturer to use the testing laboratory's certification mark, the testing laboratory shall establish a factory follow-up inspection program to determine continued compliance of certified products with the applicable standard.

(2) Follow-up inspection manual. The testing laboratory shall prepare and utilize an inspection manual setting forth the conditions governing the use of the certification mark on the products. The inspection manual shall include the identification of the products authorized for certification; identification of manufacturer and plant location at which manufacture and certification are authorized; description, specifications, and requirements applicable to the product; description of countercheck tests to be conducted in the laboratory; and description of the form and means of applying the certification mark.

(3) Follow-up procedures and activities. Follow-up procedures and activities shall include the following:

(a) Periodic unannounced inspections at the factory with testing at the factory or testing laboratory of representative samples selected from production and, if appropriate, from the market.

(b) Periodic auditing or surveillance of the manufacturer's quality assurance program through the witnessing of manufacturer's tests, review of the manufacturer's records, and verification of the manufacturer's produced data.

(c) Investigation of alleged field failures upon department request.

(d) Procedures for control of the use of the certification mark by:

(i) Keeping records of the release and use of certification marks.

(ii) Removal of marks from noncomplying products.

(iii) Return or destruction of unused marks when the authority to use the marks is terminated.

(iv) Legal action.

(e) Frequency of follow-up. The frequency of follow-up inspections shall be sufficient to provide a reasonable check on the means which the manufacturer exercises to assure that the product bearing the certification mark complies with the applicable standards. The frequency shall not be less than once each three months, unless adequate data is provided to the department to justify less frequent inspections.

WAC 296-402-130 LABORATORY APPROVAL PROGRAM IMPLEMENTATION. (1) The department may establish a standing committee for the purpose of recommending action regarding approval of electrical testing laboratories, and reviewing of applications, non-ANSI standards, and other technical criteria.

(2) The department shall develop forms and procedures which will enable applicants to submit the data necessary for evaluation.

(3) The department may waive on-site inspection for a testing laboratory showing evidence of current recognition by another state determined to provide an accreditation program acceptable to the department.

WAC 296-402-140 INITIAL LABORATORY EVALUATION. (1) The department shall:

(a) Accept requests for testing laboratory certification.

(b) Make an administrative review to ensure completeness and accuracy of information.

(c) Review the request.

(d) Arrange for laboratory on-site inspection by a technically qualified representative of the department to evaluate compliance with accreditation criteria. The cost shall be borne by the applicant.

(2) Notification of evaluation and evaluation results. The department shall notify the applicant of the recommendation of the department and time and place of the hearing to consider the request.

(3) Fees. There shall be an initial filing fee accompanying the application, an initial accreditation fee, and a biennial renewal fee as established from time to time by the department. Evaluation costs including travel expenses, and any additional related expenses shall be borne by the laboratory. On-site inspections requiring fees, shall not be made more than once a year, unless additional inspections are required by the department or requested by the laboratory.

Initial filing fee	$500.00
Initial accreditation fee:	
One product category	$250.00
Each additional category for next nineteen categories	$100.00 each
Maximum for twenty categories or more	$2150.00
Biennial renewal fee	50% of the amount of the initial accreditation fee

(4) Number and category. Each accredited testing laboratory shall be identified by the number of electrical product category(ies) that the department has determined the laboratory is qualified to evaluate. The accreditation shall indicate the electrical product category(ies) for which accreditation is issued.

(5) Approval. The department shall accept or deny laboratory approval. Such approval shall be subject to reexamination when deemed necessary by the department.

(6) Appeal. If an applicant disagrees with the action of the department regarding accreditation or qualifications, an appeal may be made to the electrical advisory board within thirty days of the notice by the department.

WAC 296-402-150 RENEWALS. (1) At least thirty days prior to the expiration date of any such accreditation, the electrical testing laboratory shall forward to the department an application for renewal. The department, upon receipt of the completed form and fee, shall renew accreditation for a period of two years or notify such applicant of the department's refusal with reasons thereof. Accreditation may be renewed for one or more electrical product category(ies) and renewal may be refused for one or more electrical product category(ies).

(2) Appeal. If an applicant disagrees with the action of the department regarding accreditation or electrical product category(ies), an appeal may be made to the electrical advisory board within thirty days of the notice by the department.

WAC 296-402-160 CONDITIONS OF ACCREDITATION. (1) Evidence of accreditation. The accreditation of any testing laboratory shall be evidenced by a letter of accreditation from the department.

(2) Period of accreditation. The accreditation of a testing laboratory shall be valid for a period of two years from the date of acceptance by the department. The period of validity shall be stated in the letter of accreditation.

(3) Maintenance of qualifying conditions. Every accredited testing laboratory shall continue to satisfy all the conditions specified in this chapter during the period of the accreditation.

(4) Reports. The accredited laboratory shall furnish the department an annual report detailing the extent of its activities for the year, and covering the products which it has certified during the year. The report shall include information concerning:

(a) The number of factory inspections.

(b) List of certified products.

WAC 296-402-170 PENALTIES. Any person and/or laboratory that fails to comply with the requirements of these rules and regulations or that files a false report may have accreditation revoked for one or more electrical product category(ies) and shall bear such cost which may accrue to the department or its agent(s) as a result of the violation. A laboratory whose accreditation has been revoked may apply again for accreditation no sooner than one year after the date of revocation of accreditation.

WAC 296-402-180 NOTIFICATION OF CHANGE. Testing laboratories accredited under these rules and regulations shall notify the department within thirty working days of any of the following:

(1) Change in company name and/or address.

(2) Changes in major test equipment.

(3) Changes in principal officers, key supervisory and responsible personnel in the company including the director of testing and engineering services, director of follow-up services, and the laboratory supervisor.

(4) Change in the standard(s) covering the certified product(s).

(5) Change in independent status.

WAC 296-402-190 REVOCATION AND SUSPENSION PROCEDURES. (1) Revocation and suspension. The department on its own initiative may suspend or revoke the accreditation of any testing laboratory found to be in noncompliance with these rules and regulations, the laws of the state of Washington, or having substantial evidence of the laboratory's conduct in unethical business practices.

(2) Notice and conference. Prior to suspension, revocation, or failure to renew the accreditation of a laboratory, written notice of such intent shall be served by registered mail by the department. Within ten calendar days of receipt of such notice, the affected laboratory may request a conference before the department. Should the electrical testing laboratory disagree with the decision of the department, an appeal may be made to the Electrical Advisory Board. Direct an appeal to Chairman, Electrical Advisory Board, 520 South Water Street, P.O. Box 9519, Olympia, Washington, 98504.

(3) Effect of suspension and revocation. If the accreditation is suspended, revoked, or not renewed, the laboratory shall immediately notify the involved manufacturers whose products are covered by the accreditation that such products manufactured subsequent to the revocation and offered for sale in the state of Washington can no longer bear the laboratory's label that identified it as a certified product.

6-1823E ✓
Bannister
2/6/90

Original sponsor(s): REP. COTTEN

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 406 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the sale or transfer of consumer electrical products."

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

* Section 1. AS 45.45 is amended by adding a new section to read:

Sec. 45.45.910. SALE OR TRANSFER OF CONSUMER ELECTRICAL PRODUCTS. (a) Unless exempted by the department under (d) of this section, a person may not sell, offer to sell, or otherwise transfer in the course of the person's business a consumer electrical product that is manufactured after the effective date of this Act, unless the product is clearly marked as being approved by an approved third-party certification program.

(b) A person may not sell, offer to sell, or otherwise transfer in the course of the person's business a consumer electrical product that is manufactured before the effective date of this Act, unless the product is clearly marked

(1) as being approved by an approved third-party certification program; or

(2) with a warning label that complies with (e) of this section.

(c) A person may not sell, offer to sell, or otherwise transfer in the course of the person's business a consumer electrical product that has been exempted under (d) of this section, unless the product is clearly marked with a warning label that complies with (e) of this section.

(d) If a consumer electrical product is a work of art or an item that has an unusual application that makes approval by a third-party certification program unavailable, the department shall upon request exempt the item from (a) of this section. The department shall establish by regulation guidelines to identify consumer electrical products that qualify for an exemption under this section.

(e) The warning label required by this section must be a brightly colored label that contains in simple, direct language a warning that the electrical product is not approved by an approved third-party certification program. The department shall adopt regulations establishing the exact content, color, design, and use of the warning label.

(f) In this section,

(1) "approved third-party certification program" means a program that meets the requirements of ANSI Z-34.1 - 1987, American National Standards for Certification - Third-Party Certification Program, published by the American National Standards Institute;

(2) "consumer electrical product" means an electrical product that is marketed for and commonly purchased by the general public and that is

(A) an assembled device that has an electrical circuit that operates at 110 volts AC or higher;

(B) a device that when assembled has an electrical circuit that operates at 110 volts AC or higher; or

(C) an individual component part that is intended to be part of an electrical circuit that operates at 110 volts AC or higher;

(3) "department" means the Department of Labor.

* Sec. 2. AS 45.50.471(b) is amended by adding a new paragraph to read:

(29) violating AS 45.45.910(a), (b), or (c).

6-1823E
Bannister
2/1/90

Original sponsor(s): REP. COTTEN

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 406 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the sale of consumer electrical products."

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

* Section 1. AS 45.50.471(b) is amended by adding a new paragraph to read:

(29) selling or offering to sell a consumer electrical product that is not listed by an approved third-party certification program or that is not clearly marked as being approved by the program; in this paragraph,

(A) "approved third party certification program" means a program that meets the requirements of ANSI Z-34.1 - 1987, American National Standards for Certification, Third Party Certification Program, published by the American National Standards Institute;

(B) "consumer electrical product" means an electrical product that uses as its original power source 110 volt AC or higher and that is marketed for and commonly purchased by the general public.

HB

429

HOUSE LABOR AND COMMERCE COMMITTEE
ALASKA STATE LEGISLATURE
P.O. BOX V, JUNEAU 99811
(907) 465-3892

HB429

February 8, 1990

M E M O R A N D U M

To: Don Koch, Division of Insurance

From: Ginger Baim, House Labor and Commerce Committee

Re: Questions on HB 429

Good morning. It is obviously going to be a humdinger today.

Enclosed is a copy of the 1989 National Indemnity Co. v. Sherman case that I'd like you to review. I think we fixed this problem with language the Division helped draft into HB 44 that addressed this loophole in the SR 22 section. Let me know if we need to make further changes because we may as well include them in HB 429, which is up again at 3:00 p.m. this afternoon.

As per our last conversation on HB 429, it appears that the bill is ready to fly except for controversy over Section 1. Below I've outlined the available options for the Committee in addressing Section 1:

1. Leave as is written in 2/6 Labor and Commerce CS so that it applies to all types of insurance for all injuries/damages and covers all attorney fees.

2. Limit attorney fees to pro rata as outlined in regulations under the Unfair Trade Practices Act.

3. Limit coverage to physical/property damage only. (All attorney fees or pro rata?)

4. Limit to automobile insurance only. (All attorney fees or pro rata?)

5. Limit to automobile physical/property damage only. (All attorney fees or pro rata?)

What we need from the Division/you is:

1) any amendments to Section 1 as it stands in the current CS that are necessary to correct any technical flaws

2) some editing of the options I've listed above (including deletions, additions, and/or cleaning up the language) so that I can list them out in a memo to the Committee without looking hopelessly confused

Section 21.36.___. SUBROGATION RECOVERIES. An insurer on a first party claim and its insured shall share in any recovery from a third party on a pro rata basis as follows:

(1) An insurer may make no deduction for subrogation expenses unless an outside attorney or other outside expert witnesses have been retained, and any deduction may be no more than a pro rata share of the insurer's costs for subrogation less any attorney fees and costs recovered. Any recovery of prejudgment interest or postjudgment interest shall be shared pro rata.

(2) An insured may deduct a pro rata share of the insured's expenses for an outside attorney or other expert witnesses, less any attorney fees and costs recovered, from the insurer's share of any recovery. Any recovery of prejudgment interest or postjudgment interest shall be shared pro rata.

(3) If an insured seperately pursues only its own interest, the insured shall bear its own expenses and the insurer may retain any subrogation recovery the insurer secures.

MEMORANDUM State of Alaska

TO: Don Koch
Acting Deputy Director

DATE: February 8, 1990

FILE NO.:

TELEPHONE NO.:

SUBJECT: CS for House Bill No. 429 (LC) Limitation on Subrogation Rights

FROM: Stan Garlington
Insurance Market Analyst

The purpose of this memorandum is to provide an analytical framework of the respective interests of insureds, insurers, and attorneys in the subrogation process, and to propose a course of action to clarify the law in Alaska on this subject.

Black's Law Dictionary defines subrogation as "the substitution of one person in the place of another with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies or securities . . . ."

Although insurance companies generally have the right to step into the shoes of the party whom they compensate and sue any party whom the compensated party could have sued, the concept of subrogation rights is generic and applies far more broadly.

Subrogation is available in first party claims in which an insurer pays a person asserting the right to payment under his or her own coverage. It may also apply to a third party claim in which any person has asserted a claim against another person. Such subrogation claims often fall into the category of contractual liability or contribution actions. It is possible that both the insured and insurer will have an interest in the subrogation recovery in both cases. Although most of us are familiar with the first party deductibles for physical damage coverage on our motor vehicle policy or property damage to the dwelling or contents on our homeowner policy, liability deductibles are quite common, as our self-insured retentions or co-insuring arrangements in which an insurer pays only a portion of the insured's liabilities to a third party.

Subrogation efforts may stand alone or be combined with other claims. An insurer may pursue a claim for monies it has paid (that is the extent of his legal right), but include in its subrogation demand the policyholder's deductible. The insured, with or without an attorney, may demand payment for the physical damage paid by its insurer along with its claim for the deductible, loss of use of the vehicle such as a car rental bill, and a bodily injury claim. Thirdly, each may pursue its own claims individually.

The Division of Insurance addressed the handling of deductibles for first party motor vehicle claims and first party property claims in the Unfair Claims Settlement Acts or Practices Regulation (3 AAC 26.010-.300. The division set as a minimum standard that the insurer include the first party's deductible, if any, in a subrogation demand unless the first party requests that it not be included or unless the deductible had been otherwise recovered by the first party claimant. The division allowed that no deduction for expense may be made from any deductible recovered unless an outside attorney or other outside expert witnesses were retained, and any reduction for them could be no more than a pro rata share of their costs, less any attorney fees and costs recovered (such as Rule 82). The division also sought to resolve the issue of both pre-judgement and post-judgement interest by advising that the interest would be shared pro rata.

In regulating the actions of insurance companies, the division did not reach the issue of proportioning a recovery made by an insured with or without an attorney. That issue has been raised by the proposed Section 21.42.285 - Limitation on Subrogation Rights.

Subrogation, as Michael J. Schneider points out in the Alaska Bar Rag, has always been viewed as an equitable concept. Before addressing the automobile medical payments coverage which troubled Mr. Schneider, I would like to consider the more straight forward situation dealing with motor vehicle physical damage first party claims. Although most of us carry policies which provide both liability coverage and physical damage coverage, many physical damage only policies are issued. Vehicle coverage may be purchased at the time a vehicle is purchased. The coverage only relates to coverage to the automobile. To put such an insurer in the position of receiving no subrogation benefits until its policyholder had been fully compensated for all losses (including, for example, extensive bodily injury claims) and all attorney fees and costs in securing the physical damage and the bodily injury settlement had been paid would be tantamount to denying subrogation as a right to such an insurer.

As long as the responsible third party has sufficient insurance coverage to pay the insured, the insurer, and the attorney, no problems arise. When the third party's ability to pay is limited, equity becomes a much more vexing issue.

The simplest approach is to continue the concept or pro rata net recovery. Disputes are unavoidable, especially in the bodily injury situation, over what the respective interests are. Most accidents do not involve clear liability, nor is the concept of general damages (such as pain and suffering) measurable. Honest minds can and do differ on both issues. However, resolving such a dispute is no different than trying to determine when an insured has been fully compensated for the loss, including costs and attorney fees incurred by the insured and relating to the loss.

Sometimes the issue may be resolved by the underlying litigation itself. Unless the third party's liability policy has limited Civil Rule 82 coverage, the parties or a court will determine what the value of the case was in order to arrive at a proper computation of Civil Rule 82. Were such as not the case, it would appear to me that, should the parties disagree, that the matter would be appropriate for arbitration.

The issue of subrogation and medical payments coverage can create a worst case scenario. The potential exists for an insured who is paid the necessary premium for first party medical payments coverage under an automobile policy to be severely injured. A $100,000 medical payment limit in a severe accident may soon be exhausted. If the other party has low limits and a policyholder must reimburse on a dollar for dollar basis, the injured will clearly not be fully compensated. A partial solution would make underinsured motorists/uninsured coverage reduced only by amounts paid by a valid and collectible automobile medical payments insurance only to the extent that such payments would be duplicative. The medical bills would be paid only once, but the full underinsured/uninsured motorists coverage would be available above the medical payments coverage if needed.

I do not believe it appropriate for a medical payments insurer to recover monies that are not related to medical bills. They should also share on a pro rata basis the costs of recovery.

I have reviewed the January 2, 1990 memorandum from Ted Lehrbach and Bob Sims regarding the legislative inquiry about State Farms' medical endorsement 6025BB. Although the filing letter suggests State Farms' intent was to "allow" the insured to be paid under both the medical payment's coverage and other sources when payment under both is required to provide the insured enough funds to pay all reasonable and necessary medical expenses, the language of the endorsement is, at best, inarticulate. It refers to "paid damages for bodily injury," not paid damages for medical expenses for bodily injury.

In order to avoid any confusion, I would recommend that language be added to the bill which makes clear that medical payments coverage is not to be duplicative of uninsured motorists coverage. That will avoid fights that the medical expenses were paid under the uninsured or underinsured motorists coverage and, therefore, are not owed under medical payments coverage, and also allow that if the medical expenses are paid under medical payments coverage, the uninsured motorists coverage would be available to its full extent for other damages.

The result would be that an insured would receive the maximum coverage.

RECOMMENDATIONS

I recommend that a new section (c) be added to AS 28.20.445 reading as follows:

> Amounts payable under the uninsured motorists and underinsured motorists coverage shall not pay again amounts paid or payable under valid and collectible automobile payments insurance.

I recommend that the expense issues of subrogated claims be handled on a pro rata basis. Including such a provision in AS 21.42 would arguably have it apply only to admitted insurers. Including it within AS 21.36, Trade Practices and Frauds, seems more appropriate. Although it may fall within AS 21.36.125, Unfair Claims Settlement Practices, it may be more appropriate to be included as a separate section because it addresses issues not included in any NAIC model with which I am familiar. At any rate, I would propose the following language:

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Section 21.36.___. SUBROGATION RECOVERIES. An insurer on a first party claim and its insured shall share in any recovery from a third party on a pro rata basis as follows:

(1) An insurer may make no deduction for subrogation expenses unless an outside attorney or other outside expert witnesses have been retained, and any deduction may be no more than a pro rata share of the insurer's costs for subrogation less any attorney fees and costs recovered. Any recovery of prejudgment interest or postjudgment interest shall be shared pro rata.

(2) An insured may deduct a pro rata share of the insured's expenses for an outside attornev or other expert witnesses, less any attorney fees and costs recovered, from the insurer's share of any recovery. Any recovery of prejudgment interest or postjudgment interest shall be shared pro rata.

(3) If an insured seperately pursues only its own interest, the insured shall bear its own expenses and the insurer may retain any subrogation recovery the insurer secures.

HB429

3AAC26.080 + 090(A)(3)

of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, the first-party claimant shall be advised in writing of the acceptance or denial of the claim;

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

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

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

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

(d) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall pay a judgment or settlement of the claim (including advances, partial settlements, or similar payments) with a negotiable check payable in cash to the payee upon presentation to a bank located in Alaska. If the check is not drawn upon a bank having a physical location in Alaska, it must be payable in cash upon presentation to at least one bank having a physical location in Alaska. (Eff. 05/06/89, Register 110)

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350
AS 21.89.030

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) If the claimant's motor vehicle is determined to be economically unrepairable and, therefore, a total loss, the person adjusting or settling the claim may not reduce the salvage value of the vehicle by charges for cleaning. (Eff. 05/06/89, Register 110).

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350

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

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

(A) offer specific comparable and available replacement property, with all applicable taxes, charges, and other fees incident to the transfer of ownership of the property at no cost to the claimant other than the deductible amount, if any, as stated in the

coverage; the offer of replacement property shall be in writing if rejected by the first-party claimant; or

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

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

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

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

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

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

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

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

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

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

(d) Any estimate of the costs of the repair of the property must be a fair and appropriate amount for which the damage can be reasonably

expected to be repaired at one or more conveniently located repair facilities, dealers, or contractors.

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

(f) If a person adjusting or settling a claim elects to have repaired a claimant's property and chooses a specific repair facility, dealer, or contractor, that person shall guarantee the repairs and cause the damaged property to be restored to its condition before the loss, at no additional cost to the claimant, and cause the repairs to be completed within a reasonable period of time. (Eff. 05/06/89, Register 110).

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350

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

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

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

(3) shall promptly make all payments or denials of payments as required by statute or regulation. (Eff. 05/06/89, Register 110)

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350

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

(1) maintain or use a statistically credible profile of medical care providers' charges on which to base payment of claims, which is updated at least every six months and contains charges for services performed not more than one year before the date of the most recent

profile; the profile must contain charges for each geographical area in which a claimant might receive treatment; if the profile does not contain a statistically credible data base for a particular medical care service in a certain geographical area, the insurer may include in the profile a sufficient number of charges for that service from another geographical area so that a reliable basis is established; however, the final basis for payment shall be adjusted to reflect the general cost differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile; the adjustment may be based on the Consumer Price Index, the medical care component of the Consumer Price Index, or another reasonable basis stated in writing; the written explanation provided to a claimant must include a complete explanation of these adjustments;

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

(b) This section does not apply to workers' compensation claims. (Eff. 05/06/89, Register 110)

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350

3 AAC 26.300. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) "working days" means all calendar days except Saturdays, Sundays, all official federal holidays, and all official Alaska holidays. (Eff. 05/06/89, Register 110)

Authority: AS 21.06.090
AS 21.36.125
AS 21.36.350

CHAPTER 31. MISCELLANEOUS

Section
50. Insurer fees
60. Miscellaneous fees

3 AAC 31.050. INSURER FEES. The following fees are established for insurers:

(1) application for a certificate of authority, including a solicitation permit and issuance of the certificate, if issued, a one-time fee of $1,000;

(2) annual continuation of a certificate of authority, $500;

(3) amendment to a certificate of authority, $100;

(4) amendment to the articles of incorporation, $100;

(5) revised bylaws or amendments to bylaws, $100;

(6) filing an annual statement, $100;

HB429

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811
(907) 465-3892

February 6, 1990

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: CS for HB 429 (L&C)
Wrok Order #6-1677E, by Ford, dated 2/6/90

The proposed CS for HB 429 incorporates new language suggested by the Division of Insurance to address the "stacking" question discussed during the February 1 House Labor and Commerce hearing.

The proposed draft allows an injured party to collect the full amount of underinsured motorist coverage available under thier own policy in addition to the full amount available through the policy of the other person/s involved in an accident, up to the amount of their actual damages. The proposed language does not change current provisions relating to "stacking".

dd/gbs90
b/hb429

HB429

From: Jay Frank 2-6-90

28.20.445 – Change subsection (a) and (b) to read:

"(a) The maximum liability of the insurance carrier under the uninsured and underinsured motorist coverage required to be offered under AS 28.20.440 shall be the lesser of:

(1) the difference between the amount of the covered person's damages for bodily injury or property damage and the amount paid to the covered person by or for any person or organization who is or may be held legally liable for the damages; or

(2) the limits of liability of the uninsured and underinsured motorist coverage.

(b) Amounts payable under the uninsured and underinsured motorists coverage may be reduced by

(1) amounts paid or payable under any worker's compensation law; or

(2) amounts paid or payable under valid and collectible automobile medical payments insurance.

HB429

LAW OFFICES

Mestas & Schneider P.C.

DENNIS M. MESTAS
MICHAEL J. SCHNEIDER

900 "N" STREET, SUITE 207
ANCHORAGE, ALASKA 99501-3298

AREA CODE 907
277-4561

January 30, 1990

VIA FAX AND MAIL

Representative Dave Donley
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Re: House Bill #429: "An Act Relating to Subrogation Provisions and Insurance Policies and To Uninsured and Underinsured Motor Vehicle Insurance"

Dear Representative Donley:

While in Juneau on the 29th of January, 1990, I received a copy of HB #429 in what I am lead to believe is its most recent form. I would recommend the following changes in this bill:

Section 3 [An Amendment of A.S. 28.20.445(c)]: The word "liability" should be stricken (after the word "vehicle" and before the word "insurance" in the first full sentence. The first full sentence should be followed by a sentence that says, in substance:

> "Underinsured motorist coverage shall be triggered by an allegation of damages in excess of available motor vehicle liability insurance coverage."

Identical changes should be made to Section 4 (Amending A.S. 28.22.221).

Getting rid of the word "liability" may not be terribly important. I'm concerned about an ambiguity that may be created by differences between "motor vehicle liability insurance" versus "uninsured" or "underinsured" motorist coverage provided on these policies. In other words, I don't want someone to argue that, because an insured is not entitled to UM or UIM coverage under their "motor vehicle liability insurance," these provisions do not apply. If "motor vehicle liability insurance" is so broadly defined in Titles 21 and 28 as to make this a non-problem, please disregard.

A problem of a more substantive nature is raised by the additional language that I propose. The bill is intended to address the problem that exists where someone with a million dollars in damages is hit by a person who has $50,000 in liability coverage and where the injured person only has $50,000 in UIM coverage. Under most current policies, coverage is not triggered because the injured person's UIM limits do not exceed the liability limits of the opposing party.

I'm simply afraid that this bill is not worded clearly enough to address that problem. The wording that I suggest triggers coverage upon the allegation of damages in excess of available liability insurance. It is important to note that the additional language that I propose does not impose liability on the carrier. It simply triggers coverage. If the insured and the insurance company cannot agree, then an arbitration can be set. It is very important, in my opinion, that this trigger of coverage be made by a mere allegation of excess damages. Otherwise, people would have to wait until the resolution of underlying liability disputes before the carrier would be given fair notice that a possible claim is out there. This would make resolution of these claims more expensive, more drawn out, and less certain. If the insurance company has a problem (a potential UIM claim), it should be given early and reasonable opportunity to evaluate that claim in the face of all available information. Thus, an allegation of damages in excess of available liability limits should be the trigger of UIM coverage.

Thanks for your consideration.

Sincerely yours,

MESTAS & SCHNEIDER, P.C.

Michael J. Schneider

kc

cc: Kent Dawson (via fax)

BEST'S INSURANCE MANAGEMENT REPORTS

Property/Casualty
Release No. 4
February 5, 1990

A.M. Best Company
Oldwick, N.J. 08858
201 439-2200

8

Average Auto Premiums By State—1988

The average annual cost to insure a private passenger automobile in the United States increased 6.3% to $517.71 in 1988, according to this report by A.M. Best Company. As was the case in 1987, Massachusetts leads the nation with the highest average premiums at $834.76, a $179.04 increase from 1987's average premiums. New Jersey, once again, had the second highest average premiums at $733.66, an increase of 15.6%—9.3 points higher than the average increase nationwide.

The state with the lowest average annual premiums, Alabama, had average premiums of $278.33. However, this figure is grossly underreported because one the state's leading writers, Champion Insurance Co., did not file an annual statutory statement with the A.M. Best Company for 1988 and was later declared insolvent by the Louisiana Department of Insurance. The average premiums for Louisiana also are underreported for the same reason. In both states, Champion Insurance wrote 5% of the total private passenger auto premiums.

Setting Alabama and Louisiana aside, Iowa had the lowest average premiums at $292.51. It is probably the only state in the Union where there is still at least a possibility of insuring a car for under $300 per year. However, another 14.4% increase like 1988's will certainly break new ground for the Hawkeye state. The next four states with the lowest average premiums, South Dakota ($324.90), Tennessee ($338.46), North Dakota ($343.85) and Idaho ($356.95), consistently have been ranked as the states with the lowest average premiums.

Apart from Massachusetts and New Jersey, the five states with the highest average auto premiums were Nevada ($691.05), California ($673.18), Pennsylvania ($620.33), Arkansas ($613.58) and Washington, D.C. ($606.39). Among these five states, Arkansas had the highest annual percentage increase at 24.1%. California drivers, who voted in November 1988 to roll back rates by 20% with Proposition 103, experienced an 8% increase from 1987 to 1988.

In 1987 four states had average premiums above the $600 level; during 1988 there were eight in this range, with Massachusetts and New Jersey in the $800 and $700 ranges, respectively. The largest concentration of states (21) grouped in the $400 range.

During 1988, there were 34 states with average automobile premiums below the national average ($517.71), compared with 30 states below the national average in 1987. These results

About This Information

The annual A.M. Best Company report on average private passenger auto premiums by state, which has been published since 1982, has again been expanded to provide more information. This year's report also includes a five year summary of the number of insurers writing auto insurance in each state.

To arrive at the average auto premiums by state, we divide private passenger auto direct premiums written for each state by the number of each state's registered vehicles, as reported by the Federal Highway Administration. Premiums for 1988 have been available since May from Best's Data Base Service, Experience By State, By Line, *however, auto registration figures are not available until December.*

Results of this study can be distorted by several factors. The Federal Highway Administration's figures include commercial passenger vehicles (taxis), but do not report pickup trucks, a popular form of private passenger transportation in the western and southern states.

Also skewing the averages is the unknown number of registered, but not insured, vehicles. Several states still do not mandate coverage, and others have varying degrees of registered, but illegally operated uninsured cars. Also affecting the averages are different states' requirements for minimum limits of coverage. Other factors that affect rates include: territory, type of vehicle, and the age of driver.

It should be noted that each year the A.M. Best Company and the Federal Highway Administration both adjust figures published in prior reports to ensure that the best currently available information is reported. These adjustments could change rankings reported in prior years' reports. □

Average Automobile Insurance Premiums by State
—Ranked by 1988 Premiums per Passenger Vehicle—

1988 Rank	State	1988 Average Premium	1987 Rank	1987 Average Premium	1986 Rank	1986 Average Premium	1985 Rank	1985 Average Premium	1984 Rank	1984 Average Premium
1	Massachusetts	634.76	1	655.72	4	555.55	3	521.40	2	488.00
2	New Jersey[1]	733.66	2	634.91	1	603.55	2	580.12	1	565.77
3	Nevada	691.05	4	600.04	5	549.49	5	498.75	6	418.99
4	California	673.18	3	623.44	3	568.20	4	503.65	5	423.49
5	Pennsylvania	620.33	9	568.99	8	512.09	7	465.03	7	418.76
6	Arkansas	613.58	21	494.29	22	433.75	18	392.27	18	349.73
7	Washington, D.C.	606.39	8	579.82	15	463.13	19	385.27	20	339.10
8	Maryland	604.41	5	597.10	9	506.34	11	423.53	11	374.20
9	Rhode Island	604.28	10	549.00	12	476.60	15	405.93	17	350.29
10	New York	601.84	7	583.67	6	522.06	6	485.07	3	453.26
11	Delaware	581.46	12	536.96	13	469.15	14	408.04	16	350.70
12	Arizona	580.47	11	548.58	10	501.70	10	426.53	10	385.86
13	Alaska	576.25	6	588.88	2	602.45	1	595.44	4	447.34
14	Connecticut	560.27	15	520.11	14	466.09	13	412.52	12	373.01
15	Hawaii	551.59	13	530.13	17	453.60	12	417.59	19	349.57
16	Georgia	529.75	20	502.39	19	450.23	22	372.06	30	305.48
17	South Carolina	526.75	16	514.93	20	449.74	17	398.86	14	365.38
	NAT'L. AVERAGE	**517.71**		**487.04**		**441.66**		**389.55**		**351.05**
18	New Hampshire	516.16	18	508.85	18	453.10	37	312.34	32	304.55
19	Michigan	509.33	17	509.29	11	481.07	16	404.63	15	359.04
20	Texas	494.66	22	473.99	23	426.09	20	383.76	13	372.48
21	West Virginia	494.06	19	507.50	16	454.65	9	426.56	8	404.97
22	Louisiana[2]	490.50	14	529.80	7	515.39	8	443.24	9	401.86
23	Colorado	474.46	28	434.97	21	444.11	21	379.16	22	329.91
24	Missouri	473.76	23	460.88	26	403.49	26	354.36	28	309.81
25	Minnesota	469.60	24	456.48	25	416.98	34	318.29	23	326.69
26	Virginia	469.54	26	436.73	31	381.82	32	325.15	38	281.17
27	Florida	462.66	29	434.00	30	390.50	29	344.98	31	304.58
28	Washington	455.25	32	430.20	29	393.86	27	351.53	25	315.99
29	Vermont	452.03	38	405.36	37	363.97	38	310.66	33	291.12
30	Illinois	448.00	25	439.13	24	418.51	25	356.00	27	312.69
31	North Carolina	445.19	35	409.82	38	362.36	35	315.75	35	285.78
32	Oklahoma	444.73	30	433.62	36	368.85	30	342.47	21	332.78
33	Oregon	444.48	27	435.09	28	396.36	28	349.68	29	306.65
34	New Mexico	439.45	34	415.57	32	378.17	23	368.43	24	325.97
35	Utah	436.10	31	430.88	27	396.78	31	329.96	36	284.22
36	Maine	435.20	41	364.59	43	332.83	43	296.71	37	283.48
37	Kentucky	431.73	36	409.51	35	369.37	33	321.83	43	268.25
38	Wisconsin	421.15	37	409.29	34	372.76	39	308.85	40	279.96
39	Indiana	414.42	33	423.18	39	360.89	42	298.08	42	268.56
40	Montana	405.86	39	405.22	33	372.96	24	360.36	26	314.46
41	Kansas	379.89	40	369.14	41	345.19	36	312.50	34	286.14
42	Ohio	376.82	42	351.01	44	327.01	45	279.39	44	260.60
43	Nebraska	367.02	43	348.27	45	323.98	44	288.02	41	269.25
44	Mississippi	360.28	46	337.01	47	297.25	47	271.02	46	250.53
45	Wyoming	359.53	45	345.02	40	347.91	40	307.51	39	281.05
46	Idaho	356.95	44	345.66	42	344.30	41	300.43	45	256.61
47	North Dakota	343.85	48	328.23	46	307.13	46	278.07	47	243.00
48	Tennessee	338.46	47	328.38	48	292.49	48	261.15	48	235.82
49	South Dakota	324.90	50	295.08	50	255.77	50	231.24	51	213.47
50	Iowa	292.51	51	255.61	51	243.95	51	214.84	49	229.89
51	Alabama[2]	278.33	49	306.76	49	278.46	49	260.63	50	224.10

(1) New Jersey average premium calculation includes $354,025,584 RMEC charges from JUA statement that were not recorded as premiums in the JUA statement.
(2) Louisiana and Alabama calculations do not include 1988 premiums for Champion Insurance Co.
* Indicates states which did not have compulsory auto insurance laws in 1988, according to AAA.
Note: Various other factors may skew results. See text for explanation of how figures are calculated.

demonstrate a growing trend that the annual growth rates among the 10 states with the highest average premiums are increasing at a rate faster than that of the rest of the nation. In fact, five of the top 10 states with the highest premium averages also were among the top 10 states with the highest growth rates as well.

Growth of Average Auto Premiums
—Five Years, by State—

87/88 Growth Rank	State	87/88 Percent Growth	86/87 Percent Growth	85/86 Percent Growth	84/85 Percent Growth	83/84 Percent Growth	82/88 Percent Growth
1	Massachusetts	27.30	18.03	6.55	6.85	17.14	118.59
2	Arkansas	24.13	13.96	10.58	12.16	18.68	134.98
3	Maine	19.37	9.54	12.18	4.67	9.58	78.79
4	New Jersey	15.55	5.20	4.04	2.54	8.55	60.93
5	Nevada	15.17	9.20	10.17	19.04	8.01	79.75
6	Iowa	14.43	4.78	13.55	-6.55	3.47	27.70
7	Vermont	11.51	11.37	17.16	6.71	12.46	72.94
8	South Dakota	10.11	15.37	10.61	8.32	2.30	61.53
9	Rhode Island	10.07	15.19	17.41	15.88	7.74	100.76
10	Colorado	9.08	-2.06	17.13	14.93	9.47	65.32
11	Pennsylvania	9.02	11.11	10.12	11.05	8.88	73.29
12	North Carolina	8.63	13.10	14.76	10.49	19.39	111.28
13	Delaware	8.29	14.45	14.98	16.35	8.48	96.16
14	California	7.98	9.72	12.82	18.93	13.28	87.93
15	Connecticut	7.72	11.59	12.99	10.59	11.00	83.22
16	Virginia	7.51	14.38	17.43	15.64	4.58	85.13
17	Ohio	7.35	7.34	17.05	7.21	9.82	66.53
18	Mississippi	6.91	13.38	9.68	8.18	4.24	66.78
19	Florida	6.60	11.14	13.19	13.27	4.47	75.20
	NAT'L. AVERAGE	**6.30**	**10.28**	**13.38**	**10.97**	**8.96**	**73.52**
20	Washington	5.82	9.23	12.04	11.24	7.65	61.03
21	Arizona	5.81	9.35	17.62	10.54	8.89	92.51
22	New Mexico	5.75	9.89	2.64	13.03	31.99	91.19
23	Georgia	5.45	11.58	21.01	21.80	6.37	106.59
24	Kentucky	5.43	10.87	14.77	19.97	11.11	90.83
25	Nebraska	5.38	7.50	12.48	6.97	4.51	48.42
26	North Dakota	4.76	6.87	10.45	14.43	-1.87	42.55
27	Wash. D.C.	4.58	25.20	20.21	13.61	12.30	129.69
28	Texas	4.36	11.24	11.03	3.03	8.49	59.43
29	Wyoming	4.21	-0.83	13.14	9.42	1.28	36.04
30	Hawaii	4.05	16.87	8.62	19.46	-3.14	51.16
31	Idaho	3.27	0.39	14.60	17.07	3.18	54.35
32	New York	3.11	11.80	7.62	7.02	7.48	56.40
33	Tennessee	3.07	12.27	12.00	10.74	9.65	71.42
34	Kansas	2.91	6.94	10.46	9.21	1.57	42.88
35	Wisconsin	2.90	9.80	20.69	10.32	13.84	83.40
36	Minnesota	2.87	9.47	31.01	-2.57	11.77	64.44
37	Missouri	2.79	14.22	13.86	14.38	6.42	79.75
38	Oklahoma	2.56	17.56	7.70	2.91	14.32	76.81
39	South Carolina	2.30	14.50	12.76	9.16	9.09	72.03
40	Oregon	2.16	9.77	13.35	14.03	1.46	52.65
41	Illinois	2.02	4.93	17.56	13.85	1.61	53.63
42	New Hampshire	1.44	12.31	45.07	2.56	4.65	96.93
43	Maryland	1.23	17.92	19.55	13.18	4.98	89.79
44	Utah	1.21	8.59	20.25	16.09	7.02	73.75
45	Montana	0.16	8.65	3.50	14.59	26.59	60.86
46	Michigan	0.01	5.86	18.89	12.70	9.38	65.90
47	Indiana	-2.07	17.26	21.07	10.99	3.62	82.96
48	Alaska	-2.15	-2.25	1.18	33.11	12.93	62.74
49	West Virginia	-2.65	11.62	6.59	5.33	13.63	43.34
50	Louisiana	-7.42	2.80	16.28	10.30	4.73	33.08
51	Alabama	-9.27	10.16	6.84	16.30	11.92	46.02

Alabama and Louisiana 87/88 growths do not include 1988 premiums for Champion Insurance Co.

New Jersey average premium calculation includes $354,025,584 RMEC charges from JUA statement that were not recorded as premiums in the JUA statement.

From 1987 to 1988, average auto premiums increased by more than the national average (6.3%) in 19 states--seven fewer states than during 1987. However, the national average growth rate for 1988 was 3.4 points lower than the 10.3% reported in 1987. Nine states reported average growth rates of 10% or more during 1988: Massachusetts (27.3%), Arkansas (24.1%), Maine (19.4%), New Jersey (15.6%), Nevada (15.2%), Iowa (14.4%) Vermont (11.5%), South Dakota (10.1%) and Rhode Island (10.1%). Montana and Michigan reported increases of less than 1%, while three states reported small declines—Indiana (2.1%), Alaska (2.2%) and West Virginia (2.7%).

During 1988, net premiums written by U.S. property/casualty insurers for private passenger automobile insurance reached $69.6 billion, an increase of 8.2% over 1987. The insurance industry experienced a $4.2 billion underwriting loss (before dividends)—which was not entirely offset by slightly more than $4 billion of investment income earned on private passenger auto premiums.

Recently released (*BIMR* Review and Preview, Jan. 2, 1990) estimates for 1989's private passenger results portend even darker shadows for insurers and consumers alike. Net premiums written for the private passenger auto lines grew by 6.6% in 1989. Unfortunately, the combined ratio rose 1.6 points to 108.2 and underwriting losses were up to $6.2 billion, a $1.4 billion (29%) increase from 1988.

With premium growth declining for the past two years and underwriting losses increasing substantially during the same period, it is easy to understand how many insurers are attempting to abandon the line. However, the A.M. Best Company study indicates otherwise. Additionally, with losses mounting it also is easy to recognize why there has been a growing number of insolvent insurersduring the past two years which primarily wrote auto lines.

From 1987 to 1988, the number of insurers writing private passenger auto actually increased from 1,121 to

1,142, for a net growth of 21—although a number of these were subsidiaries of groups. During the six-year period from 1982-1988, the number of insurers writing private passenger auto increased by 104 companies.

Texas once again may be the land of opportunity, at least for auto insurers, as 19 additional insurers began offering policies to residents of the Lone Star state last year. Texas now has 422 insurers offering auto policies, the most of any state in the nation. There are only 98 insurers—the fewest of any state—offering auto policies in Hawaii.

In 1988, Mississippi experienced the highest number (16) of insurers that stopped offering private passenger auto policies, followed closely by Louisiana (15). Massachusetts lost 12 insurers in 1988 and New Jersey lost just three.

The public's anger and frustration over increasing rates has lead to legislative battles, initiatives and the appointment of consumer watchdogs in many states. In New Jersey, the newly-elected governor was swept into office on the strength of his promise of a 20% rate rollback and further insurance reforms. Insurance rates are so high in New Jersey that the governor recently said there are between 300,000 and 400,000 uninsured vehicles on the state's highways.

Certainly, insurers are faced with a dilemma that holds little prospect for a pragmatic solution. Consumers are holding the industry responsible for the escalating repair, medical and litigation costs and no longer accepting the practice of passing along these price hikes. Fortunately, there are some insurers that have taken a leadership role and accepted the industry's charge to implement more effective cost containment measures and communicate the progress of these efforts to their policyholders. But not until the entire industry gets behind an effort to educate consumers will insurers have a chance to turn the corner toward a reasonable return on their investment.

Number of Companies Writing in State

State	1988	1987	1982	Net Change 88/87	Net Change 88/82
Alabama	272	284	301	(12)	(29)
Alaska	125	124	132	1	(7)
Arizona	302	299	291	3	11
Arkansas	241	251	264	(10)	(23)
California	372	374	359	(2)	13
Colorado	290	303	307	(13)	(17)
Connecticut	212	216	212	(4)	0
Delaware	182	187	196	(5)	(14)
Wash. D.C.	162	166	173	(4)	(11)
Florida	364	373	348	(9)	16
Georgia	348	339	315	9	33
Hawaii	98	105	105	(7)	(7)
Idaho	208	211	233	(3)	(25)
Illinois	381	382	374	(1)	7
Indiana	365	354	348	11	17
Iowa	278	290	295	(12)	(17)
Kansas	270	276	267	(6)	3
Kentucky	280	285	288	(5)	(8)
Louisiana	303	318	309	(15)	(6)
Maine	187	185	183	2	4
Maryland	257	264	237	(7)	20
Massachusetts	157	169	181	(12)	(24)
Michigan	223	237	273	(14)	(50)
Minnesota	282	285	285	(3)	(3)
Mississippi	253	269	259	(16)	(6)
Missouri	320	324	320	(4)	0
Montana	181	189	203	(8)	(22)
Nebraska	251	253	255	(2)	(4)
Nevada	206	207	220	(1)	(14)
New Hampshire	168	164	177	4	(9)
New Jersey	211	214	229	(3)	(18)
New Mexico	242	246	254	(4)	(12)
New York	260	259	279	1	(19)
North Carolina	217	217	226	0	(9)
North Dakota	203	210	213	(7)	(10)
Ohio	342	347	324	(5)	18
Oklahoma	274	286	267	(12)	7
Oregon	247	257	256	(10)	(9)
Pennsylvania	287	285	273	2	14
Rhode Island	180	177	183	3	(3)
South Carolina	178	184	209	(6)	(31)
South Dakota	203	209	222	(6)	(19)
Tennessee	310	316	297	(6)	13
Texas	422	403	385	19	37
Utah	211	220	230	(9)	(19)
Vermont	172	170	178	2	(6)
Virginia	294	285	269	9	25
Washington	262	274	265	(12)	(3)
West Virginia	190	199	191	(9)	(1)
Wisconsin	298	311	286	(13)	12
Wyoming	165	176	182	(11)	(17)
NATIONAL TOTAL	**1,142**	**1,121**	**1,038**	**21**	**104**

HOUSE COMMITTEE REPORT

(7)
Date Referred: January 19, 1990 | FURTHER REFERRALS:
JUDICIARY

Date of Committee Action: 2/8/90

The LABOR & COMMERCE Committee considered: HB 429

HOUSE BILL NO. 429 SUBROGATION OF INSURANCE CLAIMS

"An Act relating to subrogation provisions in insurance policies and to uninsured and underinsured motor vehicle insurance."

RECOMMENDATIONS:
[ ] be replaced with CS HB 429 (L&C) [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the ________ Committee

ADOPTS: ________ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact ________
[ ] zero fiscal note ________
[ ] zero with analysis ________

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) ________
[ ] zero fiscal note(s) ________
[ ] zero fn/analysis ________

SIGNING DO PASS:
Dave Donley
[signature]
[signature]
[signature]

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[signature]		X	
Drew [signature]		✓	
Mark Boyer		X	

Dave Donley
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: HB 429
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: Regarding subrogation rights in insurance policies . . . .
Sponsor: House Labor & Commerce
Requestor: House Labor & Commerce

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
_____
Components: _____
_____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) No fiscal impact for FY 90.

Prepared by: James J. Jordan, Acting Director
Division: Insurance
Phone: 465-2515
Date: 1/30/90

Approved by Commissioner: Larry Mercuilieff
Agency: Department of Commerce & Economic Development
Date: 1/30/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

LW/dg1621 5D-1/13090a

Draft #1

WORK DRAFT WORK DRAFT WORK DRAFT

6-1394A
Ford
5/4/89

IN THE HOUSE BY DONLEY

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to uninsured and underinsured motor vehicle insurance."

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

* Section 1. AS 21.89.020(c) is amended to read:

(c) An insurance company offering automobile liability insurance, or offering an excess policy of insurance that extends coverage for automobile liability, in this state for bodily injury or death shall offer coverage prescribed in AS 28.20.440 and 28.20.445, with limits equal to at least the limit purchased voluntarily to cover the insured person's liability for bodily injury or death, for the protection of the persons insured under the policy who are legally entitled to recover damages for bodily injury or death from owners or operators of uninsured or underinsured motor vehicles. The limit written may not be less than the limit in AS 28.20.440.

* Sec. 2. AS 28.20.445(c) is amended to read:

(c) If an insured is entitled to uninsured or underinsured motorists coverage under more than one policy of motor vehicle liability insurance, or under more than one coverage if two or more vehicles are insured under one policy, [THE MAXIMUM AMOUNT] an insured may recover under each policy or coverage [MAY NOT EXCEED THE HIGHEST LIMIT OF ANY ONE POLICY OR COVERAGE]. When multiple policies or coverages apply, payment may be made in the following order of priority, subject to the limit of liability for each applicable policy or coverage:

(1) a policy or coverage covering a motor vehicle occupied by the injured person at the time of the accident;

(2) a policy or coverage covering a motor vehicle that came into direct contact with the insured while a pedestrian; and

(3) a policy or coverage covering a motor vehicle not involved in the accident under which the injured person is an insured or a named insured.

HOUSE LABOR AND COMMERCE COMMITTEE
ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811
(907) 465-3892

September 28, 1989

Jim Jordan, Acting Director
Division of Insurance - DCED
3601 C Street, Suite 722
Anchorage, Alaska 99503

Dear Mr. Jordan:

I'm writing to request that the Division of Insurance implement regulations mandating that insurers offer under and uninsured motorist coverage in at least the same amounts as their insureds' highest policy limits, including umbrella policies.

As you know from speaking with Ginger Baim from my office last week, currently there are no insurers selling automobile insurance in Alaska that offer such coverage. While the law requires that they offer under and uninsured motorist coverage, the statute is silent on the question of policy limits.

Many Alaskans share my concern that they are able to provide maximum coverage to an injured party when they are at fault in an accident but are unable to procure such coverage for themselves if they are involved in an accident where an under or uninsured driver is at fault.

Please contact my office at 561-7629 upon receipt of this letter and confirm whether you will pursue this request in regulations.

Sincerely,

Dave Donley

Representative Dave Donley, Chair
House Labor and Commerce Committee

PS: The House Labor and Commerce Committee will be considering legislation dealing with other automobile insurance issues and may include this request in statute if the Division chooses not to pursue it by regulation. My first choice however, is to implement the mandate by regulations so that Alaskans can immediately benefit from this policy.

dd/gb

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

7th FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 740
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 562-3626

October 17, 1989

10/31/89

Honorable Dave Donley, Chair
House Labor and Commerce Committee
Alaska State Legislature
House of Representatives
P. O. Box V
Juneau, AK 99811

Dear Representative Donley:

RE: Under and Uninsured Motorist Coverage

This letter is to memorialize the telephone conversation I had with your staff person, Ginger Bains.

The Division of Insurance will not pursue the proposal outlined in your letter to me dated September 28, 1989. The reason for not pursuing your proposal is due to lack of statutory authority. I have conferred with Assistant Attorney General, Linda O'Bannon, to confirm the lack of direct jurisdiction in extending AS 21.89.020(c) to umbrella or excess policies.

The problem with authority rests with being able to classify an umbrella or excess policy as being an "automobile insurance policy". No definition of an automobile insurance policy exists other than in AS 21.36.310(3). (AS 21.12 does not include a specific definition and the various definitions contained are not mutually exclusive.) Umbrella or excess policies most often contain coverage for a variety of risks not associated with the operation of an automobile (eg. risks associated with a home, personal libel and slander risks). If an umbrella or excess policy only provided coverage for risks associated with automobile usage, an argument could be made that such a contract could be defined as being an automobile policy and therefore AS 21.89.020(c) would apply and the corresponding limits would have to be offered for under and uninsured motorist coverage.

I had staff do some checking as to availability of the coverage in question. State Farm offers such coverage to policyholders meeting certain underwriting criteria (see attached memorandum). Other carriers also offer coverage on a basis similar to State Farm and staff is doing further research in that respect.

One possible downside risk to legislatively mandating that under and uninsured be offered to the policy limits provided by an umbrella policy is that admitted insurers may stop offering umbrella or excess contracts. In such an event, this coverage would possibly still be offered but only by non-regulated, surplus lines, non-admitted insurers. Such insurers are not subject to AS 21.89.020.

Some other states do have programs defined by law which may meet with your concerns. Oregon has a "PIP" (personal insurance program), which may be a viable option. I invited Ginger to contact my staff directly to get the details of such plans.

Let me know if I can be of any further assistance.

Sincerely,

James J. Jordan
Acting Director

JJ/sh
2364

MEMORANDUM

State of Alaska

TO: Jim Jordan
Director
Division of Insurance

DATE: October 2, 1989

FILE NO.:

THRU: Don Koch
Chief of Market Surveillance

TELEPHONE NO.: (907) 465-2577

SUBJECT: Personal Liability
Umbrella Policy

FROM: Bob Sims
Insurance Market Analyst II
Division of Insurance
Department of Commerce
and Economic Development

Underwriting guidelines for the State Farm Policy include:

1. All auto must be insured in the voluntary market and have underlying UM/UIM coverage.

2. All other liability policies State Farm will cover must be insured with State Farm. (If you have a rental unit State Farm declines to cover you must show proof of underlying insurance up to a certain level)

3. You must be a preferred risk.

Just because you have a teenager in the household does not precluded you from being eligible for this coverage. You will just have to pay more to cover the additional risk involved.

If you want me to send you a copy of the State Farm policy and pertinent endorsements just let me know.

REPRESENTATIVE DAVE DONLEY

ALASKA STATE LEGISLATURE
DISTRICT ELEVEN • SPENARD
SEAT A

3111 "C" STREET, SUITE 450
ANCHORAGE, ALASKA 99503
(907) 561-7629

HEATHER MEADOWS • NORTHWOOD • SPENARD • THOMPSON • TURNAGAIN • UPPER MIDTOWN • WINDEMERE

CHAIRMAN
LABOR AND COMMERCE COMMITTEE

MEMBER
STATE AFFAIRS COMMITTEE
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
HOUSING AND BANKING SUBCOMMITTEE
FINANCE BUDGET SUBCOMMITTEE
DEPT. OF COMMERCE AND ECONOMIC DEVELOPMENT

May 24, 1989

Steven D. Devries
3504 Iowa
Anchorage, Alaska 99517

Dear Steven:

Representative Brown has asked that I reply to your letter to her regarding laws governing automobile insurance, particularly as it applies to under and uninsured motorist coverage.

Your letter speaks to the current statutory prohibition against "stacking" of policies so that in the case of underinsured motorist coverage the compensation to an injured party by their own insurer is reduced by the amount received from the party who injured them, up to the limit of the underinsured coverage.

I've had a bill drafted to remove this statutory prohibition and therefore permit policies to be "stacked". In addition, the draft would require insurers to offer consumers under and uninsured motorist coverage up to the limits of their base policy, as opposed to current practice where virtually all insurers offer coverage only up to the limits mandated under Alaska's mandatory insurance law.

I considered offering this draft bill as an amendment to HB 44, an act reestablishing the mandatory automobile insurance law that sunsetted on January 1, 1989. However, the press of adjournment business was such that the amendment may have delayed action on HB 44 and I decided instead to pursue it as a separate bill next year.

In the meantime, you should be aware that your letter did a lot to educate other legislators about the unfair situation created by current law and will help a great deal in seeing that we can correct the problem next year.

Thanks for writing.

Sincerely,

Representative Dave Donley

cc: Representative Brown

JUNEAU OFFICE (During Legislative Session)
P.O. BOX V, JUNEAU, ALASKA 99811 • (907) 465-3892

Kay Brown

Alaska State Legislature
House of Representatives

MEMORANDUM

TO: Rep. Dave Donley

FROM: Rep. Kay Brown

DATE: April 29, 1989

RE: HB 44, and Maximum Liability of Carrier (AS 28.22.110)

I want to bring to your attention the attached letter from Steven DeVries in which he outlines what he feels is an inequitable provision in current statute regarding liability of the insurance carrier. Although Mr. DeVries is not a constituent of mine, I feel that his concern merits attention. I would really appreciate your help in drafting a response, when you have the time.

I note that HB 44 contains the same language as AS 28.22.110, Maximum Liability of Carrier, although it repeals other provisions of AS 28.22. Is it your opinion that the existing language does not provide an unfair shield to insurers?

Thank you for your help.

P. O. Box 20-2661
Anchorage, AK 99520-2661
(907) 272-0207

During Session:
P. O. Box V
Juneau, AK 99811
(907) 465-4998

Steven D. Devries
3504 Iowa
Anchorage, Alaska 99517

January 26, 1989

Represenatative Kay Brown
Alaska State Legislature
P.O. Box V (MS3100)
Juneau, Alaska 99811

Dear Representative Brown:

On December 17, 1988, my neighbor's child, Deborah Lyons, was killed in a car accident in Anchorage. Deborah was 17 years old at the time of her death. The driver of the vehicle who struck her was an individual with a long history of serious driving offenses including DWI and Reckless Driving. Apparently, this driver was under the influence of cocaine and was driving at speeds in excess of 70mph when he ran a red light killing Deborah.

As required by state law, this driver was carrying SR22 insurance. The vehicle Deborah was driving was also insured. Her family had in effect a standard policy which provided for uninsured/underinsured motorist coverage.

In dealing with the Lyons' insurer, Allstate, it has come to my attention that a horrendous situation exists regarding an insurer's ability to escape liability from

coverage under an underinsured motorist policy. Specifically, the provisions of AS 28.22.110 provide:

> The Maximum Liability of Carrier.
>
> (a) The maximum liability of the insured's carrier under the uninsured and underinsured motorist coverage required under this chapter shall be the difference between the coverage limit of liability and the amount paid to the insured by or on behalf of the uninsured and underinsured motorist.
>
> (b) Amounts payable under the uninsured motorist and underinsured motorist coverage required to be offered under this chapter shall be reduced by
>
> (1) amounts paid or to be paid under any worker's compensation loss;
>
> (2) amounts paid or payable under any valid and collectible automobile medical payments insurance or bodily injury or death liability insurance; and
>
> (3) amounts paid by or on behalf of the uninsured or underinsured motorist.

Clearly this statute provides a windfall to insurers. Specifically, an insured purchases a policy for uninsured or underinsured motorist coverage anticipating that this policy will provide protection in the event another driver has inadequate coverage to meet all of the damages resulting from an accident. This result is clearly not obtained where the statute insulates an insurer from its primary obligation under such a coverage policy.

The windfall of which I am speaking is best illustrated under the facts that occurred in this case. Specifically, the driver of the vehicle which struck Deborah Lyons had an SR22 policy in effect which provided for $50,000 liability limitation for death or injury. The Lyons underinsurance coverage provided for a limitation of

liability in the amount of $25,000. Thus, pursuant to the terms of AS 28.22.110, it appears that the insurer is merely obligated to look to the wrongful driver's insurer for coverage. No liability will exist on the Lyons' policy because in this case the amounts otherwise available are required to be reduced by the amounts payable under the wrongful driver's SR22 policy.

As stated above, it is reasonable to attempt to protect the citizens of this state by requiring insurers provide uninsured and underinsured motorist coverage. However, this policy is clearly undermined where an insurer can escape liability by permitting an off-set. The permissibility of such an off-set generally runs counter to basic principals of law permitting an insured to be entitled to their coverage as a collateral source without permitting an insurer to escape liability by seeking to off-set. Clearly, the inequities inherent in permitting an insurer to obtain premiums for an underinsured motorist coverage on one hand and then to escape liability for that same coverage policy on the other, obviously defies logic and the clear public policy underlying the Legislature's decision to require insurers to provide such coverage.

I sincerely hope you will investigate this matter and seek to repeal this obviously inequitable, unconscionable and unfair shield granted to insurers.

Sincerely,

Steven DeVries

STEVEN D. DeVRIES

SDD:dld
SDDPER

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to subrogation provisions in insurance policies."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.285. LIMITATION ON SUBROGATION RIGHTS. (a) Notwithstanding any other provision of law, an insurance policy must provide that the insurer is not subrogated to the rights of the insured until the insured has been fully compensated for the loss, including costs and attorney fees incurred by the insured and related to the loss.

* Sec. 2. APPLICABILITY. The provisions of AS 21.42.285, added by sec. 1 of this Act, apply to contracts of insurance entered into after the effective date of this Act.

(b) the intended effect of A.S. 21.42.285(a) may not be avoided by "coverage" restrictions, exclusions, conditions or definitions contained in the 1st party policy, or any amendments thereof, or additions or endorsements thereto.

(c) a violation of A.S. 21.42.285(b) is an Unfair Trade Practice, is a violation of AS 45.50.471, and, not withstanding the provisions of AS 45.50.481 regarding exemptions, is subject to the provisions of A.S. 45.50.471-561.

Draft #2

WORK DRAFT WORK DRAFT WORK DRAFT

6-1677A
Finley
11/2/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to subrogation provisions in insurance policies."

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* Sec. 2. APPLICABILITY. The provisions of AS 21.42.285, added by sec. 1 of this Act, apply to contracts of insurance entered into after the effective date of this Act.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 998[illegible]
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M November 2, 1989

SUBJECT: Limits on subrogation in insurance policies; Work Order No. 6-1677

TO: Representative Dave Donley
Chair, House Labor & Commerce Committee

FROM: Pamela Finley PF
Assistant Revisor of Statutes

Enclosed is the draft bill concerning limitations on subrogation under insurance policies. As you requested, it covers all types of insurance. I have not discussed this with the Division of Insurance; given the potentially far reaching implications of the bill, you may want to do so, or authorize us to do so. I am especially concerned about the possibility of insurers using "coverage" limitations to avoid the intent of the section.

Please let me know if I can be of further assistance in this matter.

PF:lmb
L8/006

Enclosure

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

October 16, 1989

To: Mike Ford, Counsel
Legislative Legal Services

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: Bill Drafting request

I am writing to request a bill draft, for introduction by the House Labor and Commerce Committee, that would prohibit subrogation of an insurance claim until an injured party has been fully compensated for costs incurred, including legal fees.

Attached is a copy of an article from the Alaska Bar Rag outlining a recent action by a major insurer in Alaska that would require subrogation of claims even when it would deny an injured party adequate compensation. In a previous bill draft you have prepared for me (Work Order 6-1394A dated 5/4/89) you deal with a similar issue as it affects automobile insurance and the prohibition against "stacking" policies. This request is for a bill draft that will extend those same principles to all insurance claims.

Please contact me or Ginger Baim at 561-7629 if you have any questions or need additional information.

cc: Jim Jordan, Division of Insurance
Michael J. Schneicer

Enclosure

dd/gb

TORT LAW

Insurance carriers gut medical pay coverage

Michael J. Schneider

I. *SCOPE.*

This article will explain why many of you who believe you have medical payments coverage under your automobile insurance policy, or represent clients who believe they have such coverage in place, may end up whistling in the wind under the right (wrong) set of circumstances.

In particular, my concern is with State Farm's automobile policy. I am unaware to what extent other carriers have changed their medical pay coverage.

II. *ENDORSEMENT NO. 6025BB.*

If you or any of your clients have an auto policy with State Farm Insurance Company, you may soon be blessed with a copy of Amendatory Endorsement No. 6025BB (subrogation with a vengeance).

This endorsement purports to reduce the medical payments coverage by One Dollar for each One Dollar received by plaintiff from a liable third-party defendant. Does it make any difference to State Farm that, in many scenarios, their insured would be left with absolutely nothing, or grossly undercompensated, or with virtually no medical payments benefits in exchange for the premium that was paid? Apparently not. Here is an example. Assume that a person insured by State Farm, and with medical payments coverage limits of One Hundred Thousand Dollars ($100,000), is struck, while operating their insured vehicle, by a judgment-proof defendant. Assume that the defendant has a liability policy with a $100,000 liability limit. Assume that the plaintiff is rendered permanently disabled in some manner or other. Under State Farm's endorsement, there would be *no medical payments coverage.* It can be expected that the defendant's insurance carrier would promptly tender its liability limits. None of this money would go to do anything but pay medical expenses (and possibly attorney's fees and costs). State Farm, despite charging and retaining a premium for medical payments coverage, would be completely absolved from making any payments to its insured. Why would a "Good Neighbor" like State Farm do this?

What follows is purely speculation.

It's my recollection that State Farm medical payment coverage did not subrogate against third-party recoveries until the last few years. The original thinking was apparently that medical payments coverage was provided automatically to those people injured inside an insured vehicle and without regard to fault. Little litigation and few disputes arose surrounding this coverage and, presumably, the premium charged by State Farm and other carriers was adequate to secure what were, in essence, health-care-coverage benefits. A plaintiff that recovered against a third party for the injury would not have to pay the insurance carrier back, even if their recovery included (as it usually did) sums associated with the cost of medical care.

Like a lot of "Good Neighbors," State Farm probably decided that it could squeeze a few more dollars out of its insureds and do little or no work and spend little or no money in the process. It would simply add a policy provision that provided State Farm with a right of subrogation against any third-party recovery. State Farm policies have contained such a provision for a few years at least.

The trouble with subrogation is that it is an equitable and imperfect right. The general rule as to those insureds *who have been fully compensated*, has been expressed by our supreme court in *Cooper v. Argonaut Insurance Companies*., 556 P.2d 525, 527 (AK 1976). Our supreme court joined a majority of other courts that reasoned that it was unfair and would unjustly enrich the carrier to leave the entire burden of litigation to an injured claimant, and that a party claiming subrogation should, at a minimum, suffer a pro rata reduction in the subrogation claim by the amount of fees and costs paid by the plaintiff to generate the fund out of which the subrogation interest was satisfied. Stated simply, in a case where a plaintiff pays a one-third contingency fee to his or her attorney, the case settles with no costs expended, and the subrogated interest of a medical care provider equals Nine Thousand Dollars ($9,000.00), that provider would receive Six Thousand Dollars ($6,000.00) at the time of settlement. If the plaintiff had to pay a third to generate the fund, why shouldn't the carrier pay a third to benefit from the plaintiff's efforts?

Subrogation has always been viewed as an equitable concept, even if subrogation provisions are contained within a formal contract. Therefore, it has long been the rule in most states that the right to subrogation does not even arise until the injured party is fully compensated:

> "Although the court is persuaded that Allstate was not a 'volunteer' in making the medical payments to plaintiffs, the court is nevertheless persuaded that Allstate's subrogation claim is invalid. It is undisputed that payment of the State Farm liability policy's limits to Mr. and Mrs. Greenland will not provide them with sufficient funds to compensate them fully for the injuries they have sustained, and this court is persuaded by various decisions from other states holding that public policy bars subrogation against a source of funds which otherwise would be available to insufficiently compensated parties. *See, e.g., Transamerica Insurance Co. v. Barnes*, [illegible] P.2d [illegible] (Utah 1978); and *Mattson v. Stone*, [illegible] P.2d [illegible] (Wash. 1982)."

Gary Greenland, et al., Plaintiffs

all these equitable considerations entirely too tedious to deal with. State Farm's response is Endorsement No. 6025BB. This may place State Farm in the position of being able to argue a "coverage" question instead of a "subrogation" question.

III. *ATTACKS AND CAUSES OF ACTION RELATED TO AMENDATORY ENDORSEMENT NO. 6025BB.*

Take a look at A.S. 21.36.235 and 260. These sections apply to policies entered into or renewed on or after August 28, 1987. These sections require that notice of a reduction in coverage must be mailed to the insured twenty (20) days before expiration of a personal insurance policy, or forty-five (45) days before expiration of a business or commercial policy, and that the mailing must be by first class mail and the insurer must obtain a certificate of mailing from the U.S. Postal Service. Is mailing of a copy of the endorsement enough where its terms may not adequately communicate the manner in which coverage has been reduced? Even if your client received, read, and understood the endorsement, does the insurance carrier have the required certificate of mailing from the U.S. Postal Service? May this failure to give notice, coupled with the reasonable expectations doctrine (see various cases collected at 6 *West's Alaska Digest, Second Edition*, Insurance, Key Number 146.3(1)), provide a defense to the onerous provisions of this endorsement?

The insurance agent or broker may provide the best target for recovery where an insured has been surprised and disadvantaged by this endorsement or some similar endorsement. It is my opinion that most insurance agents and brokers do not appreciate the extent to which this endorsement guts coverage otherwise obtainable under the MPC policy. It is also my opinion that few brokers or agents have described the possible impact of this endorsement to their customers. The argument can easily be made that it is exactly this sort of professional knowledge and advice that agents and brokers have a duty to provide to their insureds, and that the failure to provide such advice is negligent. This is particularly so in face of the fact that a number of other competing insurance carriers do not impose these sorts of restrictions on their medical payments coverage.

For those of you who have not yet suffered a loss, the best remedy may simply be to vote with your feet and secure coverage from a carrier without a subrogation provision in its MPC coverage, or who, at a minimum, is willing to live with the equitable limitations imposed upon the subrogation process.

IV. *INSURANCE REFORM.*

The legislature began considering insurance reform last session. Insurance reform is likely to be an important issue in sessions to come. It might be a good idea to express your concern about insurance practices like this to members of the legislature and to suggest that mandatory medical payments coverage be made a part of Alaska's mandatory insurance law. Endorsements such as referred to above could be legislatively voided.

V. *POTENTIAL BAD-FAITH CLAIMS.*

The afore-said endorsement applies where "the injured person *has been paid* damages" (emphasis added) of any kind by the defendant. Medical payments coverage is usually paid out before third-party cases are resolved. This is particularly true in major-injury cases where there is an adequate source of recovery for plaintiff's injuries. Where liability is strong, where medical expenses are significant, but where no settlement has yet ben made, will the carrier have the courage to deny or slow pay medical payments benefits on the theory that there is "no coverage," or that coverage will be reduced if it stalls the process pending plaintiff's receipt of money from the defendant? Is it an act of bad faith (recently confirmed by our supreme court to be a tort and the possible subject of a punitive-damage award; *see State Farm Fire and Casualty Co. v. Nicholson*, Opinion No. 3465, July 22, 1988) to refuse to promptly honor a med-pay claim pending resolution of a third-party action? Will the carrier be found to have shot itself in its corporate foot without medical payments coverage to handle the hospital bills? Time will tell.

VI. *SUMMARY AND CONCLUSION.*

If your client is damaged because of a restrictive medical payments endorsement like the one discussed in this article, consider attacking the endorsement under the reasonable expectations doctrine and statutory notice provisions. Consider causes of action against the agent/broker for negligent failure to advise of the reduction in coverage and consider bad-faith and punitive-damage claims against the carrier, should the carrier refuse to provide medical payments pending the outcome of underlying third-party litigation. If you haven't suffered a loss, consider securing coverage from a company that does not impose such a restrictive endorsement upon medical payments benefits.

CLE Calendar

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

October 16, 1989

Jim Jordan, Acting Director
Division of Insurance - DCED
3601 C Street, Suite 722
Anchorage, Alaska 99503

Dear Mr. Jordan:

As per your conversation with my staff, attached is an article in the Alaska Bar Rag regarding subrogation of insurance claims. Attached also is a copy of a bill drafting request for your information.

Please comment on the following:

1. Does State Farm's endorsement, as described in this article, constitute a reduction in coverage that requires notification under AS 21.36.235-260?

2. If so, did State Farm conform to notification requirements? Are they in the process of doing so? Will the Division require them to do so?

3. Is it appropriate to prohibit the subrogation of claims unless the injured party has been adequately compensated, including legal fees? What are the pros and cons of such a prohibition as far as the industry is concerned?

4. Does the Division anticipate a problem potential bad faith claims, as outlined in paragraph "V" of the attached article, should such endorsements become more common?

I look forward to your response. Please contact me or Ginger Baim at 561-7629 if you have any questions or need additional information.

Sincerely,

Representative Dave Donley, Chair
House Labor and Commerce Committee

cc: Mike Schneider

Enclosure

dd/gb

6-1677A
Ford
12/26/89

BY THE LABOR & COMMERCE COMMITTEE

IN THE HOUSE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to subrogation provisions in insurance policies and to uninsured and underinsured motor vehicle insurance."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.285. LIMITATION ON SUBROGATION RIGHTS. Notwithstanding any other provision of law, an insurance policy must provide that the insurer is not subrogated to the rights of the insured until the insured has been fully compensated for the loss, including costs and attorney fees incurred by the insured and related to the loss.

* Sec. 2. AS 21.89.020(c) is amended to read:

(c) An insurance company offering automobile liability insurance, or offering an excess policy of insurance that extends coverage for automobile liability, in this state for bodily injury or death shall offer coverage prescribed in AS 28.20.440 and 28.20.445 or AS 28.22, with limits equal to at least the limit purchased voluntarily to cover the insured person's liability for bodily injury or death, for the protection of the persons insured under the policy who are legally entitled to recover damages for bodily injury or death from owners or operators of uninsured or under insured motor vehicles. The limit written may not be less than the limit in AS 28.20.440.

* Sec. 3. AS 28.20.445(c) is amended to read:

(c) If an insured is entitled to uninsured or underinsured motorists coverage under more than one policy of motor vehicle

liability insurance, or under more than one coverage if two or more vehicles are insured under one policy, [THE MAXIMUM AMOUNT] an insured may recover under each policy or coverage. Recovery by the insured under multiple policies or coverages is limited to the actual damages incurred by the insured [MAY NOT EXCEED THE HIGHEST LIMIT OF ANY ONE POLICY OR COVERAGE]. When multiple policies or coverages apply, payment may be made in the following order of priority, subject to the limit of liability for each applicable policy or coverage:

(1) a policy or coverage covering a motor vehicle occupied by the injured person at the time of the accident;

(2) a policy or coverage covering a motor vehicle that came into direct contact with the insured while a pedestrian; and

(3) a policy or coverage covering a motor vehicle not involved in the accident under which the injured person is an insured or a named insured.

* Sec. 4. AS 28.22.221 is amended to read:

Sec. 28.22.221. POLICY COVERAGE AND PRIORITIES. If an insured is entitled to uninsured or underinsured motorists coverage under more than one motor vehicle liability insurance policy, or under more than one coverage if two or more vehicles are insured under one policy, [THE MAXIMUM AMOUNT] an insured may recover under each policy or coverage. Recovery by the insured under multiple policies or coverages is limited to the actual damages incurred by the insured [MAY NOT EXCEED THE HIGHEST LIMIT OF ANY ONE POLICY OR COVERAGE]. Where multiple policies or coverages apply, payment shall be made in the following order of priority, subject to the limit of liability for each applicable policy or coverage:

(1) a policy or coverage covering a motor vehicle occupied by the injured person at the time of the accident;

(2) a policy or coverage covering a motor vehicle that came into contact with the insured while a pedestrian; and

(3) a policy or coverage covering a motor vehicle not involved in the accident with respect to which the injured person is an insured or a named insured.

* Sec. 5. APPLICABILITY. This Act applies to contracts of insurance entered into on or after the effective date of this Act.

6-1677E
Ford
2/6/90

Original sponsor(s): Labor & Commerce Committee

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 429 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to subrogation provisions in insurance policies and to uninsured and underinsured motor vehicle insurance."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.285. LIMITATION ON SUBROGATION RIGHTS. Notwithstanding any other provision of law, an insurance policy must provide that the insurer is not subrogated to the rights of the insured until the insured has been fully compensated for the loss, including costs and attorney fees incurred by the insured and related to the loss.

* Sec. 2. AS 21.89.020(c) is amended to read:

(c) An insurance company offering automobile liability insurance, or offering an excess policy of insurance that extends coverage for automobile liability, ~~where the excess policy identifies the vehicle or vehicles that are~~ in this state for bodily injury or death shall offer coverage prescribed in AS 28.20.440 and 28.20.445 or AS 28.22, with limits equal to at least the limit purchased voluntarily to cover the insured person's liability for bodily injury or death, for the protection of the persons insured under the policy who are legally entitled to recover damages for bodily injury or death from owners or operators of uninsured or underinsured motor vehicles. The limit written may not be less than the limit in AS 28.20.440.

* Sec. 3. AS 28.20.445(a) is repealed and reenacted to read:

(a) The maximum liability of the insurance carrier under the (1) uninsured motorists coverage required to be offered under AS 28.20.440

shall be the coverage limit of liability; and (2) under insured motorists coverage required to be offered under AS 28.20.440 shall be the coverage limit of liability and shall be applied and paid as excess to the amount insured by or paid on behalf of the underinsured motorist. Recovery by the insured is limited to the actual damages incurred by the insured unless there is bad faith on the part of insurer.

* Sec. 4. AS 28.20.445(b) is ~~amended to read:~~ repealed:

(b) Amounts payable under the uninsured motorists and underinsured motorists coverage may be reduced by

[(1)] amounts paid or to be paid under any workers' compensation law [;

(2) AMOUNTS PAID OR PAYABLE UNDER VALID AND COLLECTIBLE AUTOMOBILE MEDICAL PAYMENTS INSURANCE OR BODILY INJURY OR DEATH LIABILITY INSURANCE; AND

(3) AMOUNTS PAID BY OR ON BEHALF OF THE UNINSURED OR UNDERINSURED MOTORIST].

* Sec. 5. AS 28.20.445(c) is amended to read:

(c) If an insured is entitled to uninsured or underinsured motorists coverage under more than one primary policy of motor vehicle liability insurance, or under more than one primary coverage if two or more vehicles are insured under one policy, the maximum amount an insured may recover may not exceed the highest limit of any one primary policy or coverage. The limits imposed under this section do not apply to an excess policy of insurance that extends coverage for uninsured or underinsured motorists coverage. When multiple policies or coverages apply, payment may be made in the following order of priority, subject to the limit of liability for each applicable policy or coverage:

(1) a policy or coverage covering a motor vehicle occupied

by the injured person at the time of the accident;

(2) a policy or coverage covering a motor vehicle that came into direct contact with the insured while a pedestrian; and

(3) a policy or coverage covering a motor vehicle not involved in the accident under which the injured person is an insured or a named insured.

* Sec. 6. AS 28.22.221 is amended to read:

Sec. 28.22.221. POLICY COVERAGE AND PRIORITIES. If an insured is entitled to uninsured or underinsured motorists coverage under more than one primary motor vehicle liability insurance policy, or under more than one primary coverage if two or more vehicles are insured under one policy, the maximum amount an insured may recover may not exceed the highest limit of any one primary policy or coverage. The limits imposed by this section do not apply to an excess policy of insurance that extends coverage for uninsured or underinsured motor vehicle coverage. Recovery by the insured is limited to the actual damages incurred by the insured. Where multiple policies or coverages apply, payment shall be made in the following order of priority, subject to the limit of liability for each applicable policy or coverage:

(1) a policy or coverage covering a motor vehicle occupied by the injured person at the time of the accident;

(2) a policy or coverage covering a motor vehicle that came into contact with the insured while a pedestrian; and

(3) a policy or coverage covering a motor vehicle not involved in the accident with respect to which the injured person is an insured or a named insured.

* Sec. 7. APPLICABILITY. This Act applies to contracts of insurance entered into on or after the effective date of this Act.

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

7th FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 740
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 562-3626

January 3, 1990

Honorable Dave Donley
House Labor and Commerce Committee
Alaska State Legislature
P. O. Box Y
Juneau, AK 99811

Dear Representative Donley:

RE: State Farm Endorsement - Subrogation - Medical Payments

Attached please see the memorandum from staff which pertains to the above subject filing. (Affixed to that memorandum are copies of the filings as well as the accompanying filing letters.) Also, attached are copies of the notification forms and a brief description of the procedures State Farm utilizes in order to comply with AS 21.36.235-260.

It is noteworthy that staff research indicates that this filing brings State Farm into conformity with what the rest of the industry has been doing historically. State Farm waived its subrogation rights in the early 1980's and reinstated the subrogation feature in 1987 by way of the above subject filing.

I do not find the approval of the filing to be out of the ordinary given no statutory prohibition exists for such a subrogation provision and similar provisions were in common use by other insurers.

Let me know if I may be of further assistance.

Sincerely,

James J. Jordan
Acting Director

CC. Ted Lehrbach, Insurance Market Analyst
Bob Sims, Insurance Market Analyst

JJ/sh
2719

MEMORANDUM

State of Alaska

TO: Jim Jordan
Acting Director
Division of Insurance

DATE: Jan. 02, 1990

FILE NO.:

THRU: Don Koch
Chief of Market Surveillance

TELEPHONE NO.: (907) 465-2560

SUBJECT: Legislative Inquiry
State Farm Medical
Endorsmnt 6025BB

FROM: Ted Fehrbach and Bob Sims
Insurance Market Analysts
Division of Insurance
Department of Commerce and
and Economic Development

This memo is in regards the inquiry from Representative Dave Donley concerning the issues raised by the article in the Sept./Oct. issue of the Alaska Bar Rag written by Attorney Michael J. Schneider. In that article, Mr. Schneider raises concerns about a recent change in State Farm's Automobile policies which provides for subrogation rights on the part of State Farm for payments they may make under their Medical Pay provision, where in the past, State Farm has had no subrogation provision on file for this coverage part.

Representative Donley raised four questions regarding this change. Bob and I have done some research and have come up with the following.

1. State Farm's Amendatory Endorsement 6025BB does appear to be a reduction in coverage that would require notification under AS 21.36.235-260. We located the original filing and attach a copy for your benefit. The filing was made on September 4th, 1987, and received on September 8th, 1987. It was a filing which included two amendatory endorsements, 6025BB and 6025AC.

Endorsement 6025BB contains three separate provisions, one of which contains the amendatory language changing the medical pay provisions to allow for subrogation by the company when other medical coverage is available.

The answer to several of Rep. Donley's concerns may be put to ease by reading the cover letter of the filing. The letter outlines State Farm's clear intent to make the subrogation provisions apply in a limited manner only. It appears from their letter, items, 1, 2, & 3 on page 2, that they merely intend not to duplicate coverage that is already provided and paid, but that the Medical Payments provision will apply to those medical costs which are not paid or payable by other sources.

MEMORANDUM
Legislative Inquiry
State Farm Medical
Endorsement 6025BB

In fact, as indicated on page 3 of the letter and confirmed in our research, State Farm is attempting to bring their policy into a more standard compliance with similar policies offered by other companies, who to a large degree, never waived subrogation rights under the medical pay provisions in the past. Indeed, it appears that the history of State Farm's waiver dates back to the early 1980s when they eliminated subrogation of medical payments coverage from their auto policy.

In addition, we contacted Gary Davis of Allstate Insurance Company. He is their claims manager in Anchorage and has been handling Allstate claims in Alaska for 6 years. He indicated that to the best of his knowledge, Allstate never did have a waiver of subrogation clause in it's medical provisions in the auto policy. Their policy has always been to make the insured whole on medical costs, prior to subrogation from third party tort-feasors. He did say that they do sometimes get into disputes regarding the amount of "damages" involved in a claim, especially when policy limits are involved. But this is an issue which is commonplace in the handling of personal injury claims by their very nature.

2. Regarding the notification requirement and whether or not State Farm complied with it, I have requested a copy of the notification form which State Farm used to notify their policy holders of the changes made by the endorsements. It is their common practice to provide a notice of change with the premium notice they send to their policy holders prior to the effective date of the endorsement or the renewal date of the individual policies. We are being forwarded a copy of the form by Fax from State Farm.

We have not received any complaints regarding lack of notice by State Farm for this coverage change that we are aware of.

3. Regarding Rep. Donley's third question as to the "appropriateness" of subrogation rights by the company under the medical pay provision, I am not certain if this is really an issue which we can solve. There are pros and cons on both sides of the issue, but this may not be for us to decide as it may be better addressed either by the courts or as a policy decision by the administration or legislature. Of course any decision will have cost ramifications that may affect loss costs and thus premium levels.

Philosophically, it appears that the trend or norm in the industry has been to subrogate for medical costs, except in cases where the insured is not made whole. This is reflected in part of Mr. Schneider's article. In essence, State Farm was the exception. This raises a philosophical issue regarding their right to limit the coverage from the subrogation standpoint as do other companies, or should they to be treated differently for some unknown reason?

MEMORANDUM
Legislative Inquiry
State Farm Medical
Endorsement 6025BB

4. Finally, the fourth and last question Rep. Donley raises is the issue of bad faith claims "should such endorsements become more common?" We do not know if Rep. Donley is aware that such provisions are the norm rather than the exception but the last part of this question would seem to indicate so.

However, in contacting State Farm's representative, Mr. Mike Lessmeier, to get their side of the issue, they assure us that their policy is to make the insured whole before subrogating for medical costs paid for which have been duplicated. You may again have some arguments regarding total value of general damages for a claim, but these may be issues which can only be dealt with on an individual basis given the current form of our tort system. The intent of State Farm's endorsement appears to be pretty well outlined in their initial filing letter of September 4th, 1987. Mr. Lessmeier has provided the attached letter reconfirming State Farm's policy regarding this issue.

HUGHES THORSNESS GANTZ POWELL & BRUNDIN

ATTORNEYS AT LAW

DAVID H. THORSNESS
JAMES M. POWELL
BRIAN J. BRUNDIN
MARCUS R. CLAPP*
KENNETH P. LACOBLE
GARY W. GANTZ
JERRY E. MALCHER
JOE M. HUDDLESTON
SIGURD E. MURPHY
CARL J. B. BAUMAN
DENNIS M. BUMP*
MARY K. HUGHES
FRANK A. PFIFFNER
RALPH R. SEIBERLING*
R. CRAIG HESSEN
ROBERT L. MANLEY
JAMES N. GORSKI
TIMOTHY R. BARNES
JAMES M. BEKKEDAL
RONALD E. NOEL*
FREDERICK J. OSSEN
MICHAEL L. LESSMEIER**
STEVEN B. VERVOOREN
MATTHEW R. PETERSON
JOSEPH R. D. LOESCHER
KENNETH B. LOUGEE*
EARL M. SUTHERLAND
JOHN B. THORSNESS
THOMAS N. LUCAS

GREGORY W. LESSMEIER**
JAMES N. BARKELEY
DONNA R WALKER
WILLIAM M. WALKER
DAVID B. CARTER
JOHN G. FNANA**
ANN B. BROWN*
TIMOTHY R. REDFORD
JOHN J. NOVAK
JOHN M. TINDALL
MICKALE C. CARTER
MATTHEW G. REYNOLDS
BRYAN N. EMMAL*
ROBERT A. SPARKS*
PAUL H. CRAGAN*
GORDON W. DUVAL*
JAMES F. CLASEN
DANIEL M. WOLD
PAUL B. WILCOX
JAMES M. SWINE**
TERRY A. FIKES
KENNETH M. GUTSCH
JOHN H. RAFORTH
LYNN E. LEVENGOOD*
JOSEPH B. SLUSSER*

OF COUNSEL
JOHN C. HUGHES
RICHARD D. GANTZ

509 WEST THIRD AVENUE
ANCHORAGE, ALASKA 99501-2273
TELEPHONE (907) 274-7522
TELECOPIER: (907) 274-7528
TELEX: 090-25378 (DENALI)

**550 UNIVERSITY AVENUE
SUITE 200
FAIRBANKS, ALASKA 99709-3652
TELEPHONE (907) 479-3161
TELECOPIER: (907) 474-2529

**ONE SEALASKA PLAZA
SUITE 303
JUNEAU, ALASKA 99801-1249
TELEPHONE (907) 586-2210
TELECOPIER: (907) 463-3020

Reply to: JUNEAU

January 2, 1990

HAND DELIVERED

Mr. Ted Lehrbach
Division of Insurance
State Office Building
9th Floor
P.O. Box D
Juneau, Alaska 99811

Re: State Farm Subrogation Issues
Our File No: 220-92

Dear Ted:

In response to your inquiry regarding subrogation of MPC payments, State Farm only subrogrates or seeks reimbursement to the extent that the insured received duplicate benefits for medical bills. State Farm does not seek reimbursement when the insured has unpaid medical bills. In fact, page 9 of the August, 1988 Subrogration and Reimbursement Section of the Claim Procedures states:

> We do not collect reimbursement to the extent the amount collectable by the tort feasor will not reimburse the insured for the amount of medical bills incurred, plus reasonable attorneys fees for collection of such bills.

Turning to your other question regarding reimbursement for attorneys fees incurred on behalf of an insured, my understanding

HUGHES THORSNESS GANTZ POWELL & BRUNDIN
ATTORNEYS AT LAW

is that the dispute arises when the insured's attorney wishes to collect the duplicate payment, and at the same time the subrogation department of State Farm wishes to avoid this cost and instead collect the duplicate payment itself. State Farm believes it should have the right to collect the duplicate payment itself, if it choses to do so, and that it should not be forced to pay an attorney whose services it does not wish to utilize. I should caution this is only my understanding of this dispute, and that if you think it would be helpful, I will try to obtain more specific information, as I do believe there is ongoing litigation resolving this issue. Please let me know.

Sincerely,

HUGHES, THORSNESS, GANTZ,
POWELL & BRUNDIN

By: Michael L. Lessmeier
Michael L. Lessmeier

MLL:srs/1150L

State Farm Mutual Automobile Insurance Company

One State Farm Plaza
Bloomington, Illinois 61710

Everett J. Truttmann
Actuary
Phone: (309) 766-2041

September 22, 1987

Jim,
This is a copy of the original filing that came in Sept 198[illegible]
Bob

Mr. Bob Sims
Insurance Market Analyst
Personal Lines
Department of Commerce and Economic Development
Division of Insurance
P. O. Box D
Juneau, Alaska 99811-0800

Dear Mr. Sims:

RE: Endorsements:
6025BB - Amendatory Endorsement
6025AC - Amendatory Endorsement

This is in response to your September 11, 1987 letter, regarding the above captioned filing dated September 4, 1987. I am very pleased to hear that you welcome the changes being made by these endorsements. We certainly believe that much confusion, in regard to coverage for rental cars, will be eliminated by these endorsements.

As requested, I have attached copies of endorsements 6025BB and 6025AC. We certainly intended for copies of these endorsements to be included with the original filing, and apologize for any inconvenience caused by the delay in furnishing you copies of endorsements 6025BB and 6025AC.

We will await word from you regarding the acceptability of these endorsements before we proceed with their implementation in Alaska.

Sincerely,

Everett J. Truttmann

Everett J. Truttmann
Actuary

EJT:dl
Enclosures

September 11, 1987

Mr. Everett J. Truttmann
Actuary
State Farm Mutual Automobile
Insurance Company
One State Farm Plaza
Bloomington, IL 61710

Dear Mr. Truttmann:

Re: Endorsements 6025BB (Amendatory Endorsement)
and 6025AC (Amendatory Endorsement)

Thank you for the captioned filing dated September 4, 1987 and received in our office September 8, 1987.

Your explanation of the changes you have made in Amendatory Endorsement 6025BB are not only acceptable, but very welcome. The division has received numerous questions and complaints from many consumers regarding CDW's and what their personal auto policy covers and does not cover as far as rental cars. It is apparent from your explanation that all the confusion is eliminated in your policy and it's very clear what is and is not covered.

There is only one problem with your filing. You failed to include copies of the two captioned endorsements for me to review. Before I can approve this filing, I will need copies of those endorsements.

We will hold this filing open for 30 days to give you time to draft and send the amendatory endorsements. If we do not hear from you in that time, the filing will be considered to have been abandoned by your company. In the meantime, THIS FILING IS DISAPPROVED AND SHALL NOT BECOME EFFECTIVE. If you have any questions, please don't hesitate to give me a call at (907) 465-2517.

Yours truly,

Bob Sims
Insurance Market Analyst
Personal Lines

BS/wfs7021W
91087a

State Farm Mutual Automobile Insurance Company

One State Farm Plaza
Bloomington, Illinois 61710

Everett J. Truttmann
Actuary
Phone: (309) 766-2041

September 4, 1987

The Honorable John George
Acting Director of Insurance
Department of Commerce & Economic Development
Division of Insurance
Pouch "D"
Juneau, Alaska 99811

ATTENTION: Mr. Donald P. Koch

Dear Mr. Koch:

RE: Endorsements 6025BB - Amendatory Endorsement
6025AC - Amendatory Endorsement

Enclosed for filing on behalf of the State Farm Mutual Automobile Insurance Company of Bloomington, Illinois, are copies of endorsement 6025BB - Amendatory Endorsement.

This endorsement is being filed to make two rather significant changes in our car policy language.

One significant area of change is in regard to coverage for non-owned cars. For years, automobile policies have used terms such as "regular", "available", and "frequent" to define the scope of coverage available for an insured's use of non-owned cars. These terms are subjective and it has been particularly difficult for agents to explain in advance and to answer questions regarding the coverage an insured has for the use of non-owned cars.

In recent years, this problem has been aggravated by an increased usage of rental cars and the rental car company's continuous attempts to make the person renting the vehicle responsible for an ever increasing portion of physical damage losses.

Endorsement 6025BB revises our car policy to clearly spell out what coverage is available for the use of non-owned cars. The new language introduces objective criteria which will enable everyone to know in advance what is to be covered. The major features of the new language are as follows:

1. There is coverage for the use of non-owned cars for up to 21 consecutive days and up to 45 aggregate days in a 12-month period.

2. A car owned by a relative can now qualify as a non-owned car if certain criteria are met.

3. A car owned or leased by a non-relative resident or an employer can no longer qualify as a non-owned car regardless of the amount of use. Under the previous language there often would not have been coverage because such a vehicle is usually furnished or available for the insured's regular or frequent use.

4. We have eliminated the other insurance provision which excludes coverage for vehicles owned by a person in the car business if other coverage is available. The new policy language simply states that we provide excess coverage in regard to non-owned cars.

We feel this new language will be of significant benefit to our policyholders. It is much more objective in nature and provides a definite amount of coverage for the use of non-owned cars. The insured can be more comfortable in not purchasing the waiver of deductible when renting cars as long as the rental is within the defined boundaries of coverage.

The attached comparison provides the details of the changes in language.

The other changes made by endorsement 6025BB involve the medical payments coverage. In the early 1980's, State Farm eliminated subrogation of medical payments coverage from our car policy. As a result of this change, the medical payments coverage began, in many cases, duplicating expenses which were paid by the tortfeasor or the tortfeasor's insurer.

In an effort to help hold down the cost of automobile insurance, this endorsement adds a provision which reinstates a limited form of medical payments coverage subrogation. The new language allows the insured to be paid under both the medical payments coverage and other sources when payment under both is required to provide the insured enough funds to pay all reasonable and necessary medical expenses. However, under the new language, the following will be applicable.

1. If the injured person has already been paid for all medical expenses by the tortfeasor, the medical payments coverage will no longer duplicate these payments. If all medical expenses have not been reimbursed the medical payments coverage will pay up to its limit for unreimbursed medical expenses.

2. We will be entitled to reimbursement of any amount paid under the medical payments coverage, but only after the insured has collected sufficient funds to pay all medical expenses.

3. The liability, uninsured and underinsured motor vehicle coverages will be excess over and will not duplicate any medical expenses paid under the medical payments coverage.

The above summary provides a basic description of the new provisions. Concepts and actual policy language are more complex. We do not intend for this brief description to limit or broaden in any way what the actual policy language states. These new provisions have been designed to prevent duplication of payments for the same expenses. In fulfilling that goal, these provisions are more generous than our previous subrogation language as well as that commonly used by many other insurers. We feel this proposed approach provides a good balance between cost containment and allowing the insured to be fully compensated for incurred medical expenses.

In addition to the introduction of this new form of subrogation, the following changes are also made to the medical payments coverage:

1. We have added language to the paragraph "Medical Expenses" to better define "reasonable medical expenses".

2. The other insurance provisions of medical payments coverage have been revised to clearly avoid duplication of payments.

3. We have also added a provision to avoid stacking limits of multiple policies when an insured is occupying a non-owned car or is struck as a pedestrian.

Again, the attached comparison provides the details of these changes in policy language.

Also enclosed for filing on behalf of State Farm Mutual are copies of endorsement 6025AC - Amendatory Endorsement.

This endorsement will be used with our recreational vehicle policy to amend the definition of non-owned car, to add the new form of medical payments subrogation, and to make the other medical payments coverage changes described above for the car policy.

An effective date of December 1, 1987 is requested with the understanding we will implement these endorsements as soon thereafter as the necessary programs and procedures can be completed.

Sincerely,

Everett J. Truttmann
Actuary

EJT/cd
Enclosures

P.S. A similar filing is being made in Illinois.

State Farm Fire and Casualty Company

AUTOMOBILE ACTUARIAL DEPARTMENT
ONE STATE FARM PLAZA
BLOOMINGTON, ILLINOIS 61701

EVERETT J. TRUTTMANN, ASSISTANT SECRETARY
PHONE (309) 766-2041

September 4, 1987

The Honorable John George
Acting Director of Insurance
Department of Commerce & Economic Development
Division of Insurance
Pouch "D"
Juneau, Alaska 99811

ATTENTION: Mr. Donald P. Koch

Dear Mr. Koch:

RE: Endorsements 6025BB - Amendatory Endorsement

Enclosed for filing on behalf of the State Farm Fire and Casualty Company of Bloomington, Illinois, are copies of endorsement 6025BB - Amendatory Endorsement.

This endorsement is being filed to make two rather significant changes in our car policy language.

One significant area of change is in regard to coverage for non-owned cars. For years, automobile policies have used terms such as "regular", "available", and "frequent" to define the scope of coverage available for an insured's use of non-owned cars. These terms are subjective and it has been particularly difficult for agents to explain in advance and to answer questions regarding the coverage an insured has for the use of non-owned cars.

In recent years, this problem has been aggravated by an increased usage of rental cars and the rental car company's continuous attempts to make the person renting the vehicle responsible for an ever increasing portion of physical damage losses.

Endorsement 6025BB revises our car policy to clearly spell out what coverage is available for the use of non-owned cars. The new language introduces objective criteria which will enable everyone to know in advance what is to be covered. The major features of the new language are as follows:

1. There is coverage for the use of non-owned cars for up to 21 consecutive days and up to 45 aggregate days in a 12-month period.

2. A car owned by a relative can now qualify as a non-owned car if certain criteria are met.

3. A car owned or leased by a non-relative resident or an employer can no longer qualify as a non-owned car regardless of the amount of use. Under the previous language there often would not have been coverage because such a vehicle is usually furnished or available for the insured's regular or frequent use.

4. We have eliminated the other insurance provision which excludes coverage for vehicles owned by a person in the car business if other coverage is available. The new policy language simply states that we provide excess coverage in regard to non-owned cars.

We feel this new language will be of significant benefit to our policyholders. It is much more objective in nature and provides a definite amount of coverage for the use of non-owned cars. The insured can be more comfortable in not purchasing the waiver of deductible when renting cars as long as the rental is within the defined boundaries of coverage.

The attached comparison provides the details of the changes in language.

The other changes made by endorsement 6025BB involve the medical payments coverage. In the early 1980's, State Farm eliminated subrogation of medical payments coverage from our car policy. As a result of this change, the medical payments coverage began, in many cases, duplicating expenses which were paid by the tortfeasor or the tortfeasor's insurer.

In an effort to help hold down the cost of automobile insurance, this endorsement adds a provision which reinstates a limited form of medical payments coverage subrogation. The new language allows the insured to be paid under both the medical payments coverage and other sources when payment under both is required to provide the insured enough funds to pay all reasonable and necessary medical expenses. However, under the new language, the following will be applicable.

1. If the injured person has already been paid for all medical expenses by the tortfeasor, the medical payments coverage will no longer duplicate these payments. If all medical expenses have not been reimbursed the medical payments coverage will pay up to its limit for unreimbursed medical expenses.

2. We will be entitled to reimbursement of any amount paid under the medical payments coverage, but only after the insured has collected sufficient funds to pay all medical expenses.

3. The liability, uninsured and underinsured motor vehicle coverages will be excess over and will not duplicate any medical expenses paid under the medical payments coverage.

The above summary provides a basic description of the new provisions. Concepts and actual policy language are more complex. We do not intend for this brief description to limit or broaden in any way what the actual policy language states. These new provisions have been designed to prevent duplication of payments for the same expenses. In fulfilling that goal, these provisions are more generous than our previous subrogation language as well as that commonly used by many other insurers. We feel this proposed approach provides a good balance between cost containment and allowing the insured to be fully compensated for incurred medical expenses.

In addition to the introduction of this new form of subrogation, the following changes are also made to the medical payments coverage:

1. We have added language to the paragraph "Medical Expenses" to better define "reasonable medical expenses".

2. The other insurance provisions of medical payments coverage have been revised to clearly avoid duplication of payments.

3. We have also added a provision to avoid stacking limits of multiple policies when an insured is occupying a non-owned car or is struck as a pedestrian.

Again, the attached comparison provides the details of these changes in policy language.

An effective date of December 1, 1987 is requested with the understanding we will implement these endorsements as soon thereafter as the necessary programs and procedures can be completed.

Sincerely,

Everett J. Truttmann

Everett J. Truttmann
Assistant Secretary

EJT/cd
Enclosures

P.S. A similar filing is being made in Illinois.

6025BB AMENDATORY ENDORSEMENT

This endorsement is a part of *your* policy. Except for the changes it makes, all other terms of the policy remain the same and apply to this endorsement. It is effective at the same time as *your* policy if issued with it. If issued at a later date the name, policy number and effective date must be shown.

Issued by the STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY of Bloomington, Illinois, or the STATE FARM FIRE AND CASUALTY COMPANY of Bloomington, Illinois, as shown by the company's name on the policy of which this endorsement is a part.

Named Insured _____

Policy Number _____ Countersigned _____, 19 ____

Effective Date _____ By _____

12:01 A.M. Standard Time Authorized Representative

In consideration of the premium charged it is agreed that the following changes are made in *your* policy:

1. DEFINED WORDS

The definition of *non-owned car* is changed to read:

Non-Owned Car – means a *car* not owned by or registered or leased in the name of:

1. *you, your spouse;*
2. any *relative* unless at the time of the accident or *loss:*
   a. the *car* is or has been described on the declarations page of a liability policy within the preceding 30 days; and
   b. *you, your spouse* or a *relative* who does not own or lease such *car* is the driver.
3. any other *person* residing in the same household as *you, your spouse* or any *relative;* or
4. an employer of *you, your spouse* or any *relative.*

Non-owned car does not include a *car:*

1. which is not in the lawful possession of the *person* operating it; or
2. which has been operated by, rented by or in the possession of an *insured* during any part of each of the preceding 31 days; or
3. operated by an *insured* who has operated or rented any *car* otherwise qualifying as a *non-owned car* during any part of more than 45 days in the 365 days preceding the date of the accident or *loss.*

2. SECTION I – LIABILITY – COVERAGE A

Item 3. of "If There Is Other Liability Coverage" is changed to read:

3. Temporary Substitute Car, Non-Owned Car, Trailer.

If a *temporary substitute car*, a *non-owned car* or a trailer designed for use with a *private passenger car* or *utility vehicle* has other vehicle liability coverage on it, then this coverage is excess.

3. SECTION II – MEDICAL PAYMENTS – COVERAGE C

a. The paragraph titled MEDICAL EXPENSES is changed to read:

MEDICAL EXPENSES

We will pay reasonable medical expenses, for *bodily injury* caused by accident, for services furnished within three years of the date of the accident. These expenses are for necessary medical, surgical, X-ray, dental, ambulance, hospital, professional nursing and funeral services, eyeglasses, hearing aids and prosthetic devices. The *bodily injury* must be discovered and treated within one year of the date of the accident.

REASONABLE MEDICAL EXPENSES DO NOT INCLUDE EXPENSES:

1. FOR TREATMENT, SERVICES, PRODUCTS OR PROCEDURES THAT ARE:
   a. EXPERIMENTAL IN NATURE, FOR RESEARCH, OR NOT

PRIMARILY DESIGNED TO SERVE A MEDICAL PURPOSE; OR

b. NOT COMMONLY AND CUSTOMARILY RECOGNIZED THROUGHOUT THE MEDICAL PROFESSION AND WITHIN THE UNITED STATES AS APPROPRIATE FOR THE TREATMENT OF THE *BODILY INJURY*; OR

2. INCURRED FOR:
   a. THE USE OF THERMOGRAPHY OR OTHER RELATED PROCEDURES OF SIMILAR NATURE; OR
   b. THE USE OF ACUPUNCTURE OR OTHER RELATED PROCEDURES OF A SIMILAR NATURE; OR
   c. THE PURCHASE OR RENTAL OF EQUIPMENT NOT PRIMARILY DESIGNED TO SERVE A MEDICAL PURPOSE.

b. The provisions titled If There Are Other Medical Payments Coverages are changed to read:

If There Are Other Medical Payments Coverages

1. Non-Duplication

   No *person* for whom medical expenses are payable under this coverage shall recover more than once for the same medical expense under this or similar vehicle insurance.

2. Policies Issued by Us to You, Your Spouse or Relatives

   If two or more policies issued by us to *you*, *your spouse* or *your relatives* provide vehicle medical payments coverage and apply to the same *bodily injury* sustained:

   a. while *occupying* a *non-owned car*, a *temporary substitute car*; or
   b. as a *pedestrian*

   the total limits of liability under all such policies shall not exceed that of the policy with the highest limit of liability.

3. Subject to items 1 and 2 above:
   a. if a *temporary substitute car*, a *non-owned car* or a trailer has other vehicle medical payments coverage on it, or
   b. if other vehicle medical payments coverage applies to *bodily injury* sustained by a *pedestrian*

   this coverage is excess.

4. THIS COVERAGE DOES NOT APPLY IF THERE IS OTHER VEHICLE MEDICAL PAYMENTS COVERAGE ON A *NEWLY ACQUIRED CAR*.

c. The following is added to SECTION II – MEDICAL PAYMENTS – COVERAGE C:

When Someone May Be Legally Liable For the Bodily Injury

1. If the injured *person* has been paid damages for the *bodily injury* by or on behalf of the liable party in an amount:
   a. less than the injured *person's* total medical expenses, the most we will pay under this coverage is the lesser of:
      (1) the limit of liability of this coverage, or
      (2) the amount by which the total reasonable and necessary medical expenses exceed the total amount paid by or on behalf of all parties liable for the *bodily injury*;
   b. equal to or greater than the total reasonable and necessary medical expenses incurred by the injured *person*, we owe nothing under this coverage.
2. When we pay medical expenses under this coverage, we are entitled to be paid out of any subsequent recovery for *bodily injury* from a liable party or such party's insurer the lesser of:
   a. what we have paid; or
   b. the amount by which the sum of the total recovery for *bodily injury* from all liable parties and what we have paid under this coverage exceeds the total amount of reasonable and necessary medical expenses the injured *person* incurred.

   The injured *person* shall:
   a. execute any legal papers we need;
   b. when we ask, take action through our representative to seek a recovery;
   c. not hurt our rights to recover;
   d. not make claim to that portion of the recovery that we are entitled to be paid; and
   e. answer truthfully all questions that we may ask.

   We will not seek reimbursement from payments received from a liable party or such party's insurer by a *person* who has complied with all of these requirements.
3. The liability, uninsured and underinsured motor vehicle coverages shall be excess over and shall not pay again any medical expenses paid under this coverage.

4. SECTION IV – PHYSICAL DAMAGE COVERAGES

a. The last paragraph of "Trailer Coverage" is changed to read:

A non-owned trailer or detachable living quarters unit is one that:

1. is not owned by or registered in the name of:
   a. *you*, *your spouse*, any *relative*;
   b. any other *person* residing in the same household as *you*, *your spouse* or any *relative*; or
   c. an employer of *you*, *your spouse* or any *relative*; and
2. has not been used by, rented by or in the possession of *you*, *your spouse* or any *relative* during any part of each of the preceding 21 days; and
3. is used by *you*, *your spouse* or any *relative* and such *persons* have not used or rented any non-owned trailer or detachable living quarters unit for more than 45 days in the 365 days preceding the date of the accident or *loss*.

b. Item 3. of "If There Is Other Coverage" is changed to read:

3. Temporary Substitute Car, Non-Owned Car, Trailer.

   If a *temporary substitute car*, a *non-owned car* or trailer designed for use with a *private passenger car* has other coverage on it, then this coverage is excess.

5. CONDITIONS

a. Item a. of condition 3., "Our Right to Recover Our Payments", is changed to read:

   a. Death, dismemberment and loss of sight, total disability and loss of earnings coverage payments are not recoverable by us.

b. Item c. of condition 3., "Our Right to Recover Our Payments," is changed to read:

   c. Under all other coverages, and except as provided for within the medical payments coverage, the right of recovery of any party we pay passes to us. Such party shall:

   (1) not hurt our rights to recover; and
   (2) help us get our money back.

Edward B Rust, Jr

President