WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION

Form #3

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2005 JUL 29 P 4:04

OFFICE WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W. Va. Code §§ 33-2-10 & 33-11-4a(h)

AMENDMENT TO AN EXISTING RULE: YES X NO ____

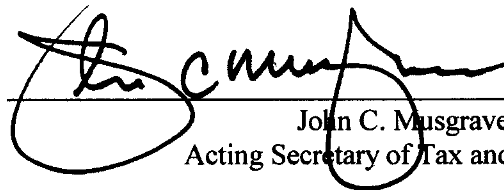
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 14

TITLE OF RULE BEING AMENDED: Unfair Trade Practices

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



John C. Musgrave
Acting Secretary of Tax and Revenue

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 29, 2005

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: UNFAIR TRADE PRACTICES (TITLE 114, SERIES 14)

1. **Authorizing statute(s) citation:**

   W. Va. Code §§33-2-10 and 33-11-4a(h)

2. a. **Date filed in State Register with Notice of Hearing or Public Comment Period:**

   June 23, 2005 - Comment Period.

   b. **What other notice, including advertising, did you give of the hearing?**

   None

   c. **Date of Public Hearing(s) *or* Public Comment Period ended:**

   Comment period ended July 25, 2005.

   d. **Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.**

   Attached __X__ **No comments received** _____

   e. **Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)**

   July 29, 2005

f. **Name, title, address and <u>phone/fax/e-mail numbers</u> of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)**

Victor Mullins, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401
Fax: (304) 558-1362
E-mail: Victor.Mullins@wvinsurance.gov

g. **<u>IF DIFFERENT</u> FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)**

Same

3. **If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:**

a. **Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.**

Not applicable

b. **Date of hearing or comment period:**

Not applicable

c. **On what date did you file in the State Register the findings and determinations required together with the reasons therefor?**

Not applicable

d. **Attach findings and determinations and reasons:**

Not applicable

NOTE: RESPONSE TO COMMENTS WILL BE FILED ON OR BEFORE AUGUST 12, 2005 PER DISCUSSION WITH DEBRA GRAHAM ON JULY 25, 2005.

TITLE 114, SERIES 14 - LIST OF COMMENTS

1) **COMMENT DATED:** July 19, 2005 (Received July 21, 2005)

RECEIVED FROM: E. R. Marks, Jr., President

ON BEHALF OF: Municipal Mutual Insurance Company

2) **COMMENT DATED:** July 19, 2005 (Received July 21, 2005)

RECEIVED FROM: L. F. Norton, Sr., Chairman

ON BEHALF OF: Inland Mutual Insurance Company

3) **COMMENT DATED:** July 21, 2005 (Received July 21, 2005)

RECEIVED FROM: James A. Dodrill
Corporate Claims Counsel

ON BEHALF OF: Progressive (group of companies)

4) **COMMENT DATED:** July 21, 2005 (Received July 22, 2005)

RECEIVED FROM: John A. Taylor, Counsel

ON BEHALF OF: GEICO (group of companies)

5) **COMMENT DATED:** July 23, 2005 (Received July 23, 2005)

RECEIVED FROM: Katy A. Gilberg
Government Relations

ON BEHALF OF: Golden Rule Insurance Company

6) **COMMENT DATED:** No Date (Received July 22, 2005)

RECEIVED FROM: Lynn Knauf
Director – Personal Lines

ON BEHALF OF: PCI - Property Casualty Insurers Association of America

7) **COMMENT DATED:** July 22, 2005 (Received July 22, 2005)

RECEIVED FROM: John D. Stuckemeyer, Counsel

ON BEHALF OF: State Farm Insurance Companies

8) **COMMENT DATED:** July 22, 2005 (Received July 25, 2005)

RECEIVED FROM: David Reddick
State Affairs Manager – Southeast Region

ON BEHALF OF: National Association of Mutual Insurance Companies (NAMIC) & 64 of its member companies

9) **COMMENT DATED:** July 21, 2005 (Received July 25, 2005)

RECEIVED FROM: Frank Norton, Jr., President

ON BEHALF OF: Safe Insurance Company

10) **COMMENT DATED:** July 22, 2005 (Received July 25, 2005)

RECEIVED FROM: Art Meadows, President/CEO
Chairman – WV Insurance Federation

ON BEHALF OF: Panhandle Farmers Mutual Insurance Company

11) **COMMENT DATED:** July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: T. Randolph Cox, Counsel
Spilman Thomas & Battle

ON BEHALF OF: American Insurance Association (AIA)

12) **COMMENT DATED:** July 21, 2005 (Received July 25, 2005)

RECEIVED FROM: E. Dennis McCormick, President
Richard A. Howard, Sr. Vice President

ON BEHALF OF: Farmers & Mechanics Mutual Insurance Co. of WV

13) **COMMENT DATED:** July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: Clarence E. (CEM) Martin, III, Esq.
Martin & Seibert, L.C.

ON BEHALF OF: Westfield Insurance Company

14) **COMMENT DATED:** July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: Tamara Lively, Executive Vice-President

ON BEHALF OF: WV Physicians' Mutual Insurance Company

15) **COMMENT DATED:** July 20, 2005 (Received July 25, 2005)

RECEIVED FROM: Mark D. Davidson
Director of Legislative Affairs
Office of Government Relations

ON BEHALF OF: Nationwide

16) **COMMENT DATED:** No Date (Received July 25, 2005)

RECEIVED FROM: Mark E. McCallister, President

ON BEHALF OF: West Virginia Association of Insurance Companies (WVAIC)

17) **COMMENT DATED:** July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: Jill C. Bentz, President

ON BEHALF OF: West Virginia Insurance Federation (WVIF)

18) **COMMENT DATED:** July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: Jill C. Bentz
Counsel for American International Group

ON BEHALF OF: American International Group (AIG)

19) COMMENT DATED: July 25, 2005 (Received July 25, 2005)

RECEIVED FROM: Jeffrey W. Williams
Regional Counsel

ON BEHALF OF: Allstate Insurance Company

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #1

Municipal *Mutual Insurance Company*
10TH AND CHARLES STS. • WELLSBURG, WEST VIRGINIA 26070 • PHONE (304) 737-3371

RECEIVED
JUL 21 2005
WVIC LEGAL DIVISION

Mr. Victor Mullins, Associate Counsel
West Virginia Insurance Commission
P O Box 50540
Charleston WV 25305-0540

SUBJECT: Unfair Trade Practices
Rule 14, Title #114

DATE: 7/19/05

Ladies or Gentlemen:

I received a copy of the proposed amendments to the Unfair Trade Practices Act yesterday and while I have not had the opportunity to spend a great deal of time studying the proposed amendments what I did see was very upsetting to me as an insurance company executive and I feel that it can be very detrimental to a company doing business in West Virginia.

Unfortunately, I have been deposed on many occasions during my insurance career and the Unfair Trade Practices Act is used solely as a tool to seek excess limits or a bad faith judgement. The act is tough enough in it's present form and really needs to come under the Insurance Departments jurisdiction rather than the court system.

Sincerely,

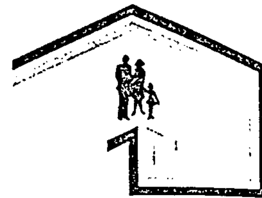
E. R. Marks, Jr.
President

ERM/s

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #2

inland mutual
INSURANCE COMPANY



July 19, 2005

Victor Mullins
Associate Counsel
West Virginia Insurance Commission
P. O. Box 50540
Charleston, WV 25305-0540

RECEIVED
JUL 21 2005
WVIC LEGAL DIVISION

Dear Mr. Mullins:

On Thursday, July 12th, we received notice of a comment period, ending July 23rd, on a proposed administrative rule regarding Unfair Trade Practices, and hence have had no time to outline the multiple specific issues that arise from the phraseology used in the document. Hence, we urge that the draft be reconsidered in a multitude of areas on a more expanded time frame than July 23, 2005.

Without any opportunity to inquire of the logic of the proposed working changes to the existing, and without spending an inordinate amount of time due to the magnitude of the document, it would be difficult to outline all of what seem to be areas needing phraseology revision. Certainly if not modified both in language and thought, the proposal, in our view, will create many new issues, only some of which were attempted to be resolved by the legislation, and unfortunately the draft seems likely to only create more contentious issues detrimental to the public-interest. Were any quantitative estimates made for the likely number and type of complaints under the revised rules?

Sincerely yours,

L. F. Norton, Sr.
Chairman, Inland Mutual Insurance Company

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #3

PROGRESSIVE

James A. Dodrill
Corporate Claims Counsel
101 Washington Street East, Suite 107
Charleston, WV 25301
Telephone: 304 348-3931
Facsimile: 304 348-3932
james_dodrill@progressive.com

RECEIVED
JUL 21 2005
WVIC LEGAL DIVISION

July 21, 2005

Victor Mullens, Associate Counsel
West Virginia Insurance Commission
Post Office Box 50540
Charleston, West Virginia 25305-0540

****VIA HAND DELIVERY****

RE: Comments Regarding Proposed Changes to 114 CSR Series 14

Dear Mr. Mullens:

Please accept this letter containing the comments of the Progressive group of companies (hereinafter referred to as "Progressive") presently authorized and doing business in West Virginia, to the proposed changes to 114 CSR Series 14 concerning the Unfair Trade Practices Rules.

Based on our internal review and an in-depth analysis by outside counsel, we find the proposed rule changes to be too onerous for a property/casualty insurer adjusting personal injury and property damage claims in West Virginia and feel they may lead to additional litigation by first and third party claimants. In all, the proposed changes include three new sections, specifically §14-8 entitled "Standards for Prompt, Fair and Equitable Settlement of Third-Party Property Damage Claims Arising Under Motor Vehicle Liability Insurance Contracts," §14-9 entitled "Third Party Administrative Complaints" and §14-10 entitled "Training and Certification." [1] In addition, there is an overhaul of §14-4 previously entitled "Unfair Or Deceptive Acts Or Practices" now entitled "Representation of Policy Provisions and Benefits." Finally, there are several name changes indicating, for example, that these are rules rather than regulations and identifying the Insurance Commission as a Commission rather than a Department. These proposed changes, just as with existing rules, apply to all lines of insurance except workers' compensation. Interestingly, the proposed change also includes in the scope of the rule a new statement ("e") indicating that "[n]othing in this rule creates or recognizes, either explicitly or impliedly, any new or different cause of action not otherwise recognized by law." Presumably, this is in reference to the recent amendment to W.Va. Code §33-11-4, which, *inter alia,* abolished a private cause of action for third party "bad faith" suits.

Below is our analysis and commentary regarding each proposed change.

Definitions

The proposed changes include additional definitions for the West Virginia Insurance Commissioner, §2.12; "licensees" which are defined as "any person that holds a license or

[1]These section numbers correlate with the proposed changes and in many instances are inserted between existing sections thus causing a renumbering of the Series. All section numbers cited herein track the proposed rules rather than the existing rules.

Certificate of Authority from the commissioner, or any other entity for whom the commissioner's consent is required before transacting business in the State of West Virginia or with residents of West Virginia," §2.13; and "Egregious Act," §2.14.

It is the definition of "egregious act" which is especially troubling. An "egregious act" is defined in §2.14 as "conduct that is clearly irresponsible, fraudulent, or malicious and reckless, whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice. An act, or failure to act, that is due to simple negligence, lack of judgment, incompetence, or bureaucratic confusion, is not an egregious act."

First, the definition seems internally inconsistent in that it adopts the standard set forth in *McCormick v Allstate*, 202 W.Va. 535, 505 S.E.2d 454 (1998), as something that does not constitute an act of "actual malice," yet finds an egregious act to be one that is "irresponsible." "Irresponsible" is analogous to negligence yet "simple negligence" is not an "egregious act" as per the definition.

Furthermore, neither the definitions nor any other section of the rule indicates who will make such findings, at what stage said findings will be made nor the burden of proof any party must bear in order for a finding of an "egregious act." Given the adoption of the legal term of "negligence," we presume the burden of proof will be by a preponderance of the evidence, yet given that the definition encompasses fraudulent acts, we would argue that such proof must be by clear and convincing evidence.

File and Record Documentation

The only substantive proposed change to §3.1 is an additional requirement that all communications, whether written or oral, be dated by the insurer and that insurers must either notate in the file or retain a copy of all forms mailed to claimants.

With respect to dating entries, given that most carriers are computerized at this time, this should not be an undue burden nor a change to everyday claim handling procedures. Moreover, notating that a form has been mailed to claimants - from the claim department - should not be a major change. However, Progressive, like some other carriers, does not have claim handling systems constructed or configured in such a way as to retain copies of forms, other than by relying upon the claim representatives to place them in "hard copy" files, and to make such a change to its systems would be, even if possible, an extremely expensive endeavor.

The only remaining issue is that the rule is unclear as to which forms it is referring. Claim forms, for example, should not be problematic. However, to the extent that "all forms" may include underwriting forms, this may be an issue. The most obvious example is a selection/rejection form for optional UM and UIM coverage limits. Said forms are generally maintained by our policy services function, but may become relevant to the handling of a claim. At a minimum, we would like to explore clarification of the rule with the Commission. This arguably applies to all incoming mail as well and may thus require a change to claim handling procedures if a carrier is not date-stamping incoming mail (Progressive does date-stamp incoming mail).

Representation of Policy Provisions and Benefits

§114-14-4 has been renamed and additional subsections have been added. Rule 4.1 now imposes positive duties on an insurer with respect to first party claimants.[2] However, the proposed rule also indicates that this positive duty also runs to beneficiaries. "Beneficiary" is not defined in the proposed rule. The West Virginia Supreme Court of Appeals held in *Bowyer by Bowyer v Thomas*, 188 W.Va. 297, 423 S.E.2d 906 (1992), that automobile liability insurance is "chiefly designed for the benefit of third parties injured by a negligent driver, and the goal of liability insurance is to extend the maximum protection possible consonant with fairness to the insurer." Given this explanation, it is reasonable to question whether inclusion of the undefined term "beneficiary" in this proposed section is intended to extend the application of this section to third party claimants.

The proposed change indicates that insurers shall disclose to a first party claimant "or beneficiary," ***all*** ("pertinent" has been deleted) benefits, coverages, time limits or other provisions of any insurance policy that may apply to the claim. When "additional benefits" might reasonably be payable upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and "cooperate with and assist the insured in determining the extent of the insurer's additional liability."

Certain portions of this proposed section seem limited to first party claims and if it is the intent of the Commission to so limit this section to first party claims, we recommend that the introductory statement delete "or beneficiary" or be amended to more fully define the scope of this section's application. Furthermore, in situations where certain coverages are not triggered by the facts of the loss, most insurers are not disclosing said coverages to claimants and, thus, this new rule may require a change to claim handling procedures. This is also problematic in instances where an insured may be presenting a UM or UIM claim and a potential *Bias* claim may exist. At the time of the initial contact with the insured, the claim representative may only have available to him or her the declarations sheet or other immediately available summary policy data and may not have access to selection/rejection forms or other similar information that might demonstrate that UM or UIM coverage is either available or may be available in a higher amount. Imposition of this new requirement would therefore be impossible for claim representatives to follow without making such underwriting documentation available to the claims department without the need for a special or more detailed request requiring significant, additional time. In addition, should this section apply to third party claims, it requires the disclosure of an insured's policy limits, which is obviously problematic. Although the West Virginia Supreme Court of Appeals has overruled an insurance carrier's arguments that revealing such nonpublic personal financial information constitutes a violation of the Gramm-Leach-Bliley Act, we nonetheless believe that an insured must first consent to the release of policy limits information in the claim process before suit is filed and the information is subject to discovery. If this section applies to third party claims and is intended to require the disclosure of

[2]The definition of a "first party claimant" remains the same. "First Party Claimant" or "Insured" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract. §2.3

an insured's policy limits, we would recommend that the section be amended to specifically identify such so as to protect against future first party claims when such information is revealed.

It is also unclear as to the intent of the Commission in the sentence that imposes additional duties upon an insurer when "additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim." Moreover, "immediately" is not defined as to any specific time frame. Given the reduction of time for other file handling activities from 15 to 10 working days, which will be discussed *infra,* we presume such time frame would apply in this situation as well.

This proposed change to §4.1 may require amendment to claim manuals, guidelines or best practices guides and will require additional training of claims personnel, particularly in centralized offices or call centers that often have initial contact with insureds, with respect to disclosure requirements.

The Commission is also proposing the addition of two subsections to this renamed section of the rule, the first being §4.4 entitled "Time limit for notification of claim." It permits a carrier to specify in its policy a time frame for a first party claimant to give notification of a claim or proof of claim. If a carrier wishes to do so, amendment to policy forms would be in order, subject to approval of the Commission's Rates and Forms Division. Otherwise, an insurer may not impose a time limit for the notification of a claim or proof of claim. This seems obviously inconsistent with applicable statutes of limitations and other sections to be discussed hereinbelow about the time in which an insured must notify an insurer of a loss and cooperate when third party claims are asserted. This is also contrary to W. Va. Code §33-6-31(e)(ii) concerning "John Doe" UM claim notification requirements that require a claimant to notify an insurance company within 60 days of the accident.

The Commission is also proposing §4.5 entitled "When settlement payment treated as communication." This section, although oddly written, essentially imposes upon an insurer the duty to explain settlement offers. Failure to explain all amounts "which should be included according to the claim filed by the claimant and investigated by the insurer" shall be deemed a communication that misrepresents a pertinent policy provision.

The West Virginia Supreme Court of Appeals held in *Miller v Fluharty*, 201 W.Va. 310, 500 S.E.2d 685 (1997), that an insurer must explain the basis of all settlement offers made in first party claims if rejecting a demand within policy limits. Such duty has never been extended beyond first party claims and this proposed subsection would expand such duty. Moreover, it is less than clear what the Commission intends an insurer to explain when it imposes a duty to explain all amounts "which should be included according to the claim filed by the claimant and investigated by the insurer." For example, if a property damage settlement is made while a personal injury or medical payments claim is pending, arguably, such additional claims must be addressed within the property damage settlement. Given the specialization of claims representatives by types of coverage with some carriers, such would be impossible. It also ignores the privacy issues that arise in claims involving different coverages.

This obviously will require 1) clarification and 2) additional training of claims personnel when communicating settlement offers. In order to protect the integrity of the claim handling process, this should also necessitate a change in procedures to make all settlement offers in writing.

Standards for the Acknowledgment of Pertinent Communications

The most pronounced change in the proposed rules falls within this section, that being the reduction of time for claims to be handled from fifteen (15) working days to ten (10) working days. This applies to acknowledgment of notices of claims, §5.1;[3] answering inquiries of the Insurance Commission, §5.2; replies to pertinent communications, §5.3; and providing assistance to first party claimants, §5.4.[4] This reduction of time also applies to the time in which insurers must commence an investigation of any claim, §6.2; the time to deny a claim or make an offer, §6.2; subsequent notifications of necessary delays in investigating claims, §6.7; notice to third party claimants of denials of claims, §8.1; and requests to third party claimants of additional information necessary to process a claim, §8.2b. Each is discussed more fully below.

We believe that the overall reduction of time for claim handling activities from 15 working days to 10 working days is adverse to the interests of the insurance industry and will lead to an increased number of timeliness violations. It is particularly troubling to the extent it applies to "pertinent communications" since plaintiff's counsel could easily barrage a claim representative with "pertinent communications" many of which could not be responded to within such a short time. In addition, day-to-day practice would indicate that certain information vital to an investigation such as the request for a police report or medical records can not be obtained within 10 working days and will now impose additional requirements on a claim representative to explain why more than 10 working days is required to complete certain tasks and respond to "pertinent" communications or to make settlement offers.

With respect to acknowledgment of notices of claims, §5.1, the Commission has also proposed an additional provision that permits notification of claims to be made to agents that will constitute notice to the insurer. The new provision states that "[i]f notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent promptly notifies the claimant in writing that the agent is not authorized to receive notices of claims."

This is also problematic in several ways. First, "agent" is broadly defined in the rule as "any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim." §2.1 (emphasis added). It does not appear from this definition that "agent" is intended to cover selling agents. Yet, the proposed change to §5.1 would lead one to conclude that selling agents could receive notices of claims. [5] Second, assuming selling agents are to be receiving initial notices of claims, extensive training will be required in order to assure that such notices are timely responded to and forwarded to claims, particularly given the

[3]This proposed amendment imposes the restricted time limitation unless full payment is made within such period of time.

[4]Although not specifically addressed, we presume for purposes of this analysis that the reduced time frame of 10 business days will apply to the newly imposed disclosure requirements of §4.1.

[5]Some companies, such as State Farm Mutual Automobile Insurance Company, encourage insureds to make initial notices of claims through their selling agents.

reduction of time to respond from 15 working days to 10 working days. Third, the term "promptly" is not defined to cover instances in which selling or other "agents" are not authorized to receive notices of claims. (This is the same for the proposed amendment to §6.2). In the event a carrier chooses not to authorize selling agents to receive notices of claims, a form notice should be created and a process instituted whereby said form is transmitted to the claim department to comply with proposed §3.1. Fourth, this section does not address the situation of carriers, like Progressive, utilizing independent selling agents and will require a carrier-specific business decision as to whether to authorize said independent selling agents to receive notices of claims. This section also does not address the needs of insurers, also like Progressive, who engage in direct marketing and sales via the Internet. Finally, the proposed new language is difficult to follow and we would suggest that the language be changed to that stated in §6.2

Standards for Prompt Investigation and Fair And Equitable Settlements Applicable To All Insurers

This section contains several changes and additions. First, the Commission is proposing a new §6.1 entitled "Investigation of claims" which again imposes a positive duty on insurers to "promptly" conduct and "diligently pursue" a "thorough, fair and objective investigation" and not to "unreasonably" delay resolution by "persisting" in seeking information "not reasonably required for or material to the resolution" of a claim dispute. While this is a good statement of public policy and one would hope all carriers would conduct such investigations in pursuit of a resolution of a claim, it is problematic in that the terms are vague and ambiguous, subject to myriad interpretations and apparently left to the discretion of the Commissioner and/or juries who may consider first party "bad faith" claims without regard to evidentiary standards or further definition.

§ 6.2 only proposes to reduce the time frame for investigations from 15 to 10 working days and changes language concerning notices of claims to agents as discussed above. However, the Commission has made no changes to what we perceive to be an internal inconsistency in the language of the existing rule. The first sentence of this section refers to "any claim filed by a claimant" which would therefore include third party claims. However, the next sentence, requiring notification of items, statements and forms, is limited by its language to first party claimants. We believe this is internally inconsistent and this would be an appropriate time to clarify of existing language as well.

The Commission also proposes to add a requirement in §6.3 that within 10 working days of the completion of its investigation the insurer must either deny the claim in writing, or make a written offer, subject to policy limits. But for the reduced time limitations, we have no criticism of this proposed addition. However, this may require some change to claim handling procedures for certain companies.

The Commission has also proposed a change to §6.4 governing settlement offers. The existing language of the rule states, in pertinent part, "[i]n any case where there is no dispute as to coverage or liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable..." The Commission now proposes to change the word "or" to "and." Additionally, as with the existing rule, this section ignores "damages" or "causation" disputes as a basis for not making settlement offers, and this failure needs to be addressed.

More troubling than this change, however, is the proposed addition to §6.4 which states: "If the claim presented is greater than policy limits, then the claimant must be so advised. Offers must be calculated in third party claims in the same manner as would be used if the claim were made under a first party coverage by one of its insureds." This again calls for the disclosure of an insured's liability limits to a third party which is a violation an insurer's duty to its insured as discussed, *infra*.

This proposed addition is silent as to how the claimant must be advised if the carrier evaluates the claim in excess of policy limits; however, given the overall preference for written communication, throughout the rule, we presume this too is to be in writing. The proposed addition is also silent as to what information must be presented to a claimant about the evaluation process utilized by the insurance carrier and the valuation placed on the claim by the carrier. Moreover, the requirement that offers in third party claims must be calculated in the same manner as first party claims is unclear and will require clarification before we can comment further on this provision.

Especially troubling about this proposed addition is the imposition of a requirement upon a carrier to advise a claimant - first or third party - as to its evaluation when the value exceeds policy limits. This overlooks the recurrent situation of a claim in which the same carrier has both liability and underinsured exposure - sometimes referred to as "cross files" or "double width" files. It is prejudicial to the interests of the carriers and potentially the tortfeasor in such situations for a claim representative handling the liability claim to reveal the evaluation that might expose the excess carrier and potential personal assets of the tortfeasor. Moreover, to the extent that the West Virginia Supreme Court of Appeals has imposed a duty on liability carriers to act in good faith toward excess carriers, revealing an evaluation and presumably the value placed upon a claim simply because it exceeds liability limits could violate the dictates of *State ex rel. Allstate v Karl,* 190 W.Va. 176, 437 S.E.2d 749 (1993), *cert. denied*, 570 U.S. 1194 (1994). This new requirement overlooks the practicalities of day-to-day claim handling as well. Often times a claim will clearly exceed policy limits based upon limited investigation, i.e., a clear liability death claim with a minimum limit liability policy. In such instances, very little investigation and little to no evaluation of damages may be performed by the liability carrier in order to determine that the claim exceeds available policy limits. Rather than just offering the limits, this new section seems to suggest that a carrier must nonetheless complete a liability and damages analysis and place a value on the claim so as to provide it to the third party claimant because the value of the claim is greater than policy limits. This, therefore, would slow rather than speed the claim handling process in contravention of the stated purpose and the presumed intent of the rules. Furthermore, the proposed amendment is silent as to the admissibility, if any, of the disclosure by the carrier of its evaluation when the value exceeds available policy limits. It is foreseeable that in the context of a UIM claim that the liability carrier would now be required to disclose its evaluation of the claim which the claimant would then use in pursuit of a UIM claim and might attempt to introduce the liability carrier's evaluation as "proof" as to the value of the claim.

If passed, this section would require extensive re-training of claim representatives and potentially the creation of additional forms for the disclosure of an evaluation when a claim exceeds available policy limits.

PROGRESSIVE

The Commission has further attempted to change the manner in which claims are adjusted by the proposed addition of §6.5 entitled "Unreasonably low offers." While clearly it is the goal of carriers not to make unreasonably low offers, attempts to regulate against such activity are problematic, particularly as stated in the proposed addition. The Commission is interjecting itself into the claim adjustment process by this proposed addition and also seeks to invade the attorney-client privilege. Due to the damaging nature of this proposed addition, it is cited in its entirety for your review and consideration as well:

> 6.5 Unreasonably low offers. – No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:
>
> a. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
>
> b. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;
>
> c. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
>
> d. The extent to which the insurer considered the advice of its counsel regarding the likelihood of recovery in excess of policy limits;
>
> e. The procedures used by the insurer in determining the dollar amount of property damage;
>
> f. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and
>
> g. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

This section is obviously troubling in many regards. First, it is unclear when the Commissioner may become involved in reviewing such issues and again contains vague and ambiguous terms such as "unreasonably low," "credible evidence" and apparently imposes a new standard that being what a "reasonable person would have offered in settlement of the claim taking into consideration the relevant facts and circumstances at the time the offer was made."

Moreover, this new section appears in direct contravention to the recent amendment to the Unfair Trade Practices Act which states: "[a] good faith disagreement over the value of an action or claim or the liability of any party to any action or claim is not an unfair claims settlement practice." W. Va. Code §33-11-4a(g).

To the extent the determination of what constitutes an "unreasonably low offer" requires consideration of advice of an insurance carrier's counsel, (subsection d) this is a blatant

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violation of the attorney-client privilege. As written, this section automatically waives the privilege and permits inspection of advice of counsel. In that it is vaguely written, we presume this would apply only to counsel hired to defend or provide advice to the insurance carrier rather than defense counsel hired to defend the insured, but would strongly suggest that 1) this provision be eliminated or 2) be clarified as to which counsel this section applies. Clearly, an insured has the right to counsel and communications, even as between the carrier and the insured's counsel, are protected by the *quasi* attorney-client privilege. *State ex rel. Allstate v Gaughan,* 203 W.Va. 358, 508 S.E.2d 75 (1998). The traditional attorney-client privilege applies to insurance carriers who retain counsel directly, including in the defense of UIM or UM claims adverse to the insured, *State ex rel. Allstate v Madden,* 215 W.Va. 705, 601 S.E.2d 25 (2004). To permit the Commissioner, or any other individual the unfettered right to review advice of counsel when the carrier has not made a case-by-case decision as to whether to waive the privilege is tantamount to a complete evisceration of the privilege and should be vigorously opposed during this comment period.

Moreover, the likelihood of an excess verdict is not the proper standard when considering a first party claim. If a carrier defends a claim such as a UIM claim and a verdict is returned in excess of policy limits, the burden then shifts to the carrier in a subsequent "bad faith" claim to demonstrate - by clear and convincing evidence - that it acted as a reasonably prudent insurer would under the same or similar circumstances. *Marshall v Saseen,* 192 W.Va. 94, 450 S.E.2d 791 (1994).

It is also unclear why the Commissioner, in the context of a personal injury claim, would specifically consider procedures used by an insurer in determining the dollar amount of property damage, (subsection e). We believe this is incorrectly placed in this subsection and has no bearing on whether an insurer made an "unreasonably low offer" of a personal injury claim. To the extent the Commissioner chooses to monitor or regulate property damage claims by reviewing procedures insurers utilize in determining the dollar amount of property damage claims, this subsection should be placed in a later paragraph of the rules which specifically governs property damage.

Consistent with all other changes to the rule about statements being made in writing, the Commission is striking any other method of denying a claim in §6.6. We do not find this to be problematic and feel that it, in fact, promotes good claim handling.

As with other time requirements, the Commissioner is proposing changing the time in which to provide notice of delays in investigating claims in §6.7. The existing language of the rule limited this subsection, previously §6.5, to first party claims. Such limitation is now proposed to be stricken. As to <u>all</u> claims, the Commission is attempting to require insurers to notify <u>all</u> claimants within 10 rather than 15 working days if more time is necessary to investigate a claim. As proposed, a carrier would be entitled to 30 calendar days from the date notice of a claim is received to determine if a claim should be accepted or denied. If additional investigation is necessary, a carrier would now be required to notify a claimant of such in writing within 10 working days after the 30 day period expires and every 30 calendar days thereafter until the investigation is complete. The application of this section is proposed to be restricted so that carriers are relieved of this obligation when investigating claimants the carrier suspects fraudulently caused a loss. The section presently exempts a carrier from this notification

requirement not only for those suspected of causing a loss but also those who contributed to the loss.

Conversely, however, the application of the section is proposed to be expanded in that it is presently confined to suspected losses "caused by arson." Arson is proposed to be excluded and thus this section would now arguably apply to all losses in which fraud is suspected. In that regard, the Commission is proposing additional language which states: "[n]othing contained in this subsection shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim." We have no criticism of the proposed expansion of this subsection to cover all suspected fraudulent losses. If passed, however, additional training of all claim representatives, particularly of those in "SIU" or similar roles, would be required.

The Commission is also proposing a new section entitled "Disclaiming coverage" at §6.10. This new section would impose upon a carrier the duty to notify a claimant in writing as soon as it is determined that there was no policy in force or that the carrier is disclaiming liability because of a breach of policy provisions by the policyholder. Specific reasons for disclaiming coverage are required. We have no objection to this subsection as it applies to situations where there is no policy in force and assume most carriers, like Progressive, are presently notifying claimants in writing of such occurrences. Problematic, however, is the provision that a carrier must explain its specific reason for disclaiming liability because of a breach of policy provisions by the policyholder. Assuming, for purposes of this discussion, the Commission has not confused liability and coverage denials, then typically, this would be a breach of the cooperation clause. This proposed section does not take into consideration the requirements of Syllabus Point 1 of *Thomas, supra,* which states that before an insurance policy will be voided because of the insured's failure to cooperate, such failure must be substantial and of such nature as to prejudice the insurer's rights. In addition to prejudice, the insurer must show that its insured willfully and intentionally violated the cooperation clause of the policy before it can deny coverage. *Id.*, Syl. Pt. 2; see also *Charles v State Farm Mut. Auto. Ins. Co.*, 192 W.Va. 293, 452 S.E.2d 384 (1994). Reliance upon this proposed rule change without the additional showings could thus subject a carrier to a first party "bad faith" claim. This additional demonstration of prejudice is set forth in proposed §8.3 which will be addressed *infra,* and we propose that this provision either 1) be deleted in its entirety or 2) amended to be consistent with applicable case law.

The Commission has also added a new section, §6.12 entitled "Responsibility for use of data" which is very problematic and may be impossible for carriers to meet. This new section would again impose additional responsibilities upon carriers, specifically to demonstrate the accuracy of data used to establish the value of insurance claims including when a computerized database source is used. While at first blush it does not seem unreasonable that a carrier should be responsible for the accuracy of data, when it comes to the use of computerized databases provided by outside vendors, it imposes an undue and likely unattainable responsibility on insurers to verify the data of others over which it presumably has no control. The use of computerized databases is on the rise with insurance carriers across all lines of coverage. Many carriers utilize Colossus® or similar software to evaluate personal injury claims and similar databases to evaluate medical bills and almost all carriers use NADA, Mitchell's or CCC® to estimate the value of automobiles. Quite frankly, this appears to be a trial-lawyer

driven attack on the use of such databases such as the class action litigation we have seen across the country on this issue. We draw to your attention, however, that the West Virginia Insurance Commissioner has approved the use of many non-published data services, such as CCC® for the purposes of evaluating motor vehicle values and thus it must be presumed that carriers have met their burden of demonstrating the accuracy of data used in such approved databases. *See*, Informational Letter No. 143. Previously, the responsibility to establish reliability rested between the vendor and the Commissioner and such responsibility should not be shifted to the carriers.

Moreover, to the extent an outside vendor has control of the underlying data in many instances and that said data changes constantly, it is highly prejudicial to the interests of any carrier to be held responsible for the accuracy of such ever-changing information. Presumably, a carrier is responsible for any data it maintains in-house for the evaluation of personal injury claims such as the baseline information of Colossus® or similar software. The Commissioner proposes to exempt any responsibility for data provided by any governmental entity unless the carrier is on notice of such inaccuracy and nonetheless continues to use the data.

This section, like many others, is silent as to when this information will be considered by the Commissioner, the burden of proof, discovery issues, the preservation of trade secret or proprietary information as protected by *State ex rel. Johnson v Tsapis*, 187 W.Va.337, 419 S.E.2d 1 (1982), and the production of this information to claimants and/or their counsel contrary to marketing agreements and other objections of the vendors who may not have the right to intervene in any administrative process. Provisions for the protection of trade secrets similar to those found in §7.2 concerning "official used car guides" should be inserted into this section if it is to be enacted. Additionally, several carriers have agreements with private vendors concerning notification and intervention rights and, therefore, such vendors should be immediately notified of this proposed rule change to the extent any vendor may wish to oppose such during the public comment period.

The Commissioner has also proposed a new section, §6.17, which prohibits carriers from compensating employees, agents or contractors based upon savings from claim denials. While on its face, this does not appear to be objectionable, there could be corporate incentives that have claims payments as a mere component. A broad reading of this section may therefore invalidate these programs. Further, if an employee's eligibility for a bonus, incentive or other additional compensation program is based upon a level of claims handling that considers, directly or indirectly, claims payments, closings without payment, trade combined ratios, etc., such eligibility requirements may bring the incentive plans into question.

§ 6.18 seeks to limit information adjusters can utilize when dealing with unrepresented claimants and prohibits carriers from explaining the merits, or lack thereof, of retaining counsel or engaging a public adjuster. This is clearly aimed at Allstate's "Do I Need An Attorney?" letter, but some adjusters do engage in mathematical equations with unrepresented adjusters explaining that net recovery may be greater if a settlement is reached while the claimant is unrepresented. To the extent adjusters utilize this negotiation tactic, it must be curtailed if this subsection is enacted.

We have no objection to the proposed addition of §6.19 that would prohibit an insurer from deducting premiums owed from a claim payment.

§6.20 restricts an insurer's ability to request income information to only those claims involving a fire loss, loss of profits or loss of income. This obviously overlooks personal injury claims in which permanency is alleged and would thus deprive a carrier of the right to investigate if the claimant is in fact permanently injured or whether the claimant is engaged in some work activity thus defeating certain claims.

We have no objection to proposed §6.21 that would prohibit an insurer from requesting or requiring a claimant to submit to a polygraph examination unless authorized by the policy or state law or if the claimant gives written consent.[6]

The Commissioner is proposing several additions to the rule concerning subrogation claims. We find the addition of any section concerning subrogation to be incongruent with the Unfair Trade Practices Act. The UTPA governs claim settlement practices. Subrogation is not, by definition, a claim settlement practice and thus should fall outside the purview of Series 14. Subrogation does not involve either a first party or third party claimant as defined by the rule and any attempt to pursue subrogation is not a claim settlement practice. Thus, we propose that §6.22 be stricken in its entirety as beyond the subject of the UTPA and rules that may be promulgated thereunder.

Assuming for purposes of this analysis only, however, that subrogation claims are to be governed by this Series, we will nonetheless share our opinions concerning the proposed section.

First, the proposed section prohibits subrogation until a carrier has conducted a "thorough, fair and objective investigation as to whether subrogation is appropriate." While we have no objection to this preamble as we are conducting due diligence in this and other aspects of our business, we question its necessity in the rule. This appears to be an avenue for the subversion of the civil justice process whereby a defendant in a subrogation claim could file an administrative complaint with the Commission seeking its determination as to whether subrogation is appropriate rather than defending the suit at a court of law.

With respect to the actual requirements of pursuing subrogation, the Commission seeks to impose several new notification requirements that will require the creation of forms and additional training of claims personnel.

Section 6.22a would require an insurer to provide written notification to first party claimants as to whether the insurer intends to pursue subrogation. If not pursuing subrogation, the notification must include a statement that any recovery to be pursued is the "responsibility" of the first party claimant. We find the use of the term "responsibility" in any such mandated notification troubling

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[6]This section permits the use of polygraphs or other truth detection devices if authorized under the applicable insurance contract. Any carrier wishing to utilize such devices may consider changing its policy language subject to approval by the Commission's Rates and Forms Division.

since presumably a carrier is not pursuing subrogation because it has determined that recovery is unlikely. To indicate to an insured that it has a "responsibility" beyond contractual obligations is therefore misleading. This section would not apply if the carrier: 1) waives the insured's deductible; 2) no deductible applied to the claim under which coverage was paid; 3) the loss sustained does not exceed the deductible or 4) there is no legal basis for subrogation.

If pursuing subrogation, a carrier would now be required to include in any subrogation demand the insured's deductible. Moreover, §6.22b requires insurers to share subrogation recoveries. The manner of sharing recoveries, however, appears to be incorrect in its language. As written, the proposed subsection states: "[e]very insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount." It seems the Commission intends to preserve the right of the insured to recover the full amount of the deductible; however, as written, an insurer must also presumably share subrogation recoveries above the deductible. This could result in a double recovery to the insured. Moreover, the section does not address the "made whole" doctrine and again we would propose striking this subsection in its entirety. Alternatively, this clause should be rewritten to permit a proportionate sharing of any recovery up to the deductible, but permit carriers to recoup 100% of any remaining subrogation recovery which is statutorily and contractually permitted, to include attorney fees and costs, if appropriate.

The proposed section also states that no insurer may deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency and then only permits the deduction on a pro rata share of the allocated loss adjustment expense. As written, it would be possible for an insured to be allocated legal and other expenses that would exceed the recovered deductible. This also interferes with any contract an insurer and/or insured may have entered into with outside counsel. Deductions should be pursuant to the fee agreement with the outside counsel or collection agency without regard to the carrier's internal allocated loss adjustment expense.

The Commission is also proposing the addition of a section indicating that no insurer may require a claimant to withdraw, rescind or refrain from submitting any complaint to the commissioner regarding the handling of a claim as a condition precedent to the settlement of any claim, §6.23. We object to the inclusion of this section as it would eliminate any ability of a carrier to settle a claim globally.

The Commissioner is also seeking to require additional information when claims are denied. § 6.24 would require any notice rejecting <u>any element</u> of a claim involving personal <u>property</u> insurance to contain specific policy and claim number information and provide the claimant notice that the claimant has the option of contacting the Commissioner and requires a notice providing the physical and mailing address, telephone number and web site of the Insurance Commission. We question why this notice is required at all, but if so, why limited to personal property claims. This notice would be mandated and would be yet another form to be created by carriers in order to be compliant with these rules. Moreover, it seems to be an invitation to file administrative complaints over denials of any property damage claims to the Commissioner and we find no public policy reason why such claims are deserving of additional notices.

Standards for Prompt, Fair and Equitable Settlement Applicable to Automobile Insurance

The only proposed change to this paragraph is contained in §7.2-2E concerning conditioning deductions for automobiles. Conditioning deductions must be "reasonably based on a physical attribute that has the effect of decreasing the vehicle's value." To the extent this subsection deals with total losses of vehicles, it does not appear that this will be extremely problematic; however, the Commissioner fails to define the criteria for conditioning deductions. Taken in a vacuum of the universe of claims, taking a conditioning deduction from an NADA retail value may not fall within the "physical attribute" characterization.

Standards for Prompt, Fair and Equitable Settlement of Third Party Claims

The Commission is proposing the addition of a new section, specifically §114-14-8, which is by its title limited to third party claims and which applies only to property and casualty insurance contracts. This section is in addition to all other provisions of the rule. This section also requires action within ten (10) working days and imposes the additional duty in third party claims that upon receipt of a notice of claim, if the insurer has a "good faith belief that it is not liable for any payment," then the insurer must so notify the claimant, in writing. Such notice requires that the insurer furnish the claimant its policy number and deny the claim, setting forth the reason(s) therefor.

We obviously object to the restricted time frame. This new requirement may also require the creation of an additional form notice for such situations but is essentially no different than current claim handling requirements concerning the denial of a claim. Likewise, if the insurer is unable to verify coverage, the written acknowledgment to the claimant must so advise of this situation as per proposed §8.2a. The only troubling aspect to this proposed addition is the requirement that notice to a claimant must "request any additional information as may be needed to ascertain the existence or absence of coverage." From a practical standpoint, we question how a third party claimant might have any information that might assist an insurer in determining the existence of coverage for an alleged insured.

The written acknowledgment when coverage is known to exist also has specific information which must be included as per proposed §8.2b. When coverage is known to exist, the written acknowledgment shall inform the claimant that the insured has a policy which, to the extent of the insured's negligence and up to policy limits, provides coverage for property damage, including loss of use and any other out-of-pocket expenses reasonably attributable to the accident. This section seems limited to property damage claims and it is uncertain whether said notification is required in personal injury claims. This will require further clarification from the Commission.

Concurrent with this acknowledgment, the insurer must provide either a claim form or request by telephone or personal contact any pertinent additional information necessary for the insurer to reach a final evaluation of the claim. Furthermore, within 10 working days of acknowledgment of the claim or receipt of the information requested when acknowledging the claim, the insurer must request any additional information required to process the claim. Finally, during the pendency of a claim, if additional information is necessary the insurer must request such information within 10 working days. This proposed section demonstrates little to no

understanding of claim handling activities in that neither a claimant nor an insurer may know all information reasonably necessary to reach a final evaluation of a claim when a claim is first made. To the extent this proposed section is intended to apply to personal injury as well as property damage claims, certain elements of personal injury claims are not readily known when claims are first noticed, such as permanency, future medical expenses or any other element of future damages. To impose a 10 working day limit to request information that clearly would not be initially available is incongruent with prompt and efficient claim handling.

Similar to §6.10, the Commission is also proposing a new section with respect to an insurer's duties when a policyholder fails to cooperate with the processing of a claim. Pursuant to proposed §8.3, if a claimant has given notice of a claim, but has not received notice from the policyholder, then the insurer must within seven (7) working days of notice from the claimant, notify the policyholder that failure to give notice and to cooperate may result in the company disclaiming liability and the potential for personal liability. Please note that the time to provide said notice to the policyholder is even more restricted. Moreover, this proposed section mandates the creation of another form, one that shall be furnished the policyholder to permit the policyholder to detail the incident.[7] This subsection would not apply if the insurer accepts and documents a telephone or personal contact which has resulted in securing the required information. Despite this mandated notification, the proposed section concludes by stating: "[n]o insurer may deny or fail to adjust an otherwise valid third party claim because of the failure of the insured to cooperate unless the insurer can prove the lack of cooperation is material, substantial and to the prejudice of the insurer." While this language tracks that of the *Thomas* and *Charles* opinions cited above, it still fails to include the requirements of Syllabus Point 2 of *Thomas* that the insurer must show that its insured willfully and intentionally violated the cooperation clause of the policy before it can deny coverage. We can also anticipate arguments from third party claimants that any attempts to disclaim coverage due to the policyholder's failure to cooperate in the investigation of the claim is contrary to W. Va. public policy and the financial responsibility statute.

Finally, the proposed amendment indicates that the section is not applicable to subrogation claims. We do not believe that subrogation should be included at all in this rule as per the discussion, *infra*.

Third Party Administrative Complaints

As per W. Va. Code §33-11-4a, the Commission is proposing rules governing the third party administrative complaint procedure. However, the proposed rule is contrary to the statute and does not provide the mandatory forms as required by W. Va. Code §33-11-4a(b)(1) nor has the Commission released proposed procedural rules as required. We have been advised that the Commission is currently preparing forms, but to our knowledge none have yet been made available although such complaints could be filed after July 8, 2005.

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[7]Note that proposed §8.3 only discusses disclaiming liability while proposed §6.10 discusses and possibly confuses disclaiming coverage and liability.

Proposed §9.1 requires an insurer to advise the Commissioner within 45 days after receiving notice of an administrative complaint of the status of negotiations with the claimant. This is a shorter time frame than permitted under W. Va. Code §33-11-4a(b)(4) and (5) which permits insurers 60 days after receiving notice of the complaint to attempt to "cure" the situation and so advise the Commission.

Proposed §9.2 also differs from the procedure set forth in W.Va. Code §33-11-4a(c). The proposed section includes contingencies that permit a claimant to control the administrative process, which is arguably to the detriment of the insurer.

W.Va. Code §33-11-4a(c) states:

> If the third-party claim is not resolved within the sixty-day period described in subdivision (4), subsection (b) of this section through either the person's substantial correction of the circumstances giving rise to the alleged violation or an offer from the person to resolve the administrative complaint that is found to be reasonable by the Commissioner, the Commissioner shall conduct any investigation he or she considers necessary to determine whether the allegations contained in the administrative complaint are meritorious.

Proposed §9.2 states:

> If, within sixty (60) days after the insurer receives notice of a third party administrative complaint, the complainant has rejected all offers or has not responded to the last offer made, the commissioner shall determine whether the final offer was reasonable. If the insurer makes no offer during said time period, the commissioner shall determine whether an offer should have been made under the circumstances. ... For purposes of this subsection, an "offer" is a proposal to correct the alleged unfair claim settlement practice.

As you can see, the two sections differ. The Code is silent as to subsequent offers by the insurer and rejection and/or no response by the claimant. Our concern is that an insurer shall attempt to "cure" by making an offer and the claimant simply will not respond, thus triggering the hearing process. Permitting a claimant to invoke a hearing process by simply not responding is arguably permitting a claimant to act in "bad faith" by not fully participating in the settlement process which should be against public policy, will cause the Commissioner to incur significant investment of her assets in investigating such complaints and is to the detriment of insurers. Moreover, this entire process will require the Commissioner to review every offer made by an insurer once a third party administrative complaint is filed simply to determine if the subsequent offer constitutes either a "substantial correction of the circumstances" as stated in the Code or whether the final offer was "reasonable" as stated in the proposed rule. Finally, the proposed rule is silent as to the second tier investigation permitted by the Code via the Consumer Advocate. Per W. Va. Code §33-11-4a(d), the Commissioner was granted the right to promulgate procedural rules for hearings. No proposed procedural rules have been released. Hearings, however, could begin as early as September 12th and it is unknown how those hearings shall be conducted, the information which may be considered, or the burden of proof, etc.

Damages are also addressed in the proposed new section which tracks, in part, the damages permitted in the Code. Proposed §9.4 outlines the two types of restitution permitted to a claimant, i.e., actual economic damages and noneconomic damages not to exceed $10,000.00 as set forth in W. Va. Code §33-11-4a(e)(2)(A)and (B), but fails to recite the remainder of (B) which prohibits restitution for attorney fees and punitive damages. We believe this should be incorporated into the language of the proposed rule to completely cite the pertinent Code provision.

Moreover, we urge the Commissioner to promulgate the mandatory forms for the filing of third party administrative complaints and to issue procedural rules relative to administrative hearings as per the Code.

Training and Certification

Finally, the Commissioner is proposing the addition of a section that would require certification of training concerning the proposed rule changes.

§ 10.1 would require every insurer to adopt and communicate to its claims agents written standards for the prompt investigation and processing of claims within 90 days of the effective date of the rule. Given that most insurers already have such written standards, we do not believe this will be an undue burden.

§ 10.2, however, will require immediate training and/or re-training of the claims force and potentially training of selling agents should an insurer elect such agents to accept notification of claims. § 10.2 would require insurers to provide "thorough and adequate training regarding this rule" to all claims agents. Furthermore, insurers would now be required to certify that claims agents, except for licensed attorneys, have been trained regarding this rule and any revisions thereto.

Insurers must demonstrate compliance with this proposed new section by annual certification, in writing, under penalty of perjury. Individual licensees (i.e., adjusters) will be required to annually certify that he or she has read and understands this rule and any and all amendments thereto. §10.2a. Insurers must annually certify that: 1) its claims manual contains a copy of this rule and all amendments thereto; and 2) that clear written instructions regarding the procedures to be followed to effect proper compliance with this rule and all amendments thereto were provided to all its claims agents. §10.2b. Moreover, insurers must provide training to insurance adjusters regarding this rule and annually certify such. A copy of the certification shall be maintained at all times at the principal place of business of the licensee, provided to the insurance commissioner only upon request. Annual certifications are required by September 1 of each year.

This proposed change will at a minimum require amendment to claim manuals to insert the new rules - if passed - and will require immediate training of claims personnel as well as the creation of forms for the annual certification. It is unclear who will or should execute the certification and we presume the carriers will make an internal decision as to the best person to certify that the carrier's claim manual contains a copy of the rule and all amendments thereto, that clear written instructions regarding the procedures to be followed were provided to all claim agents and that

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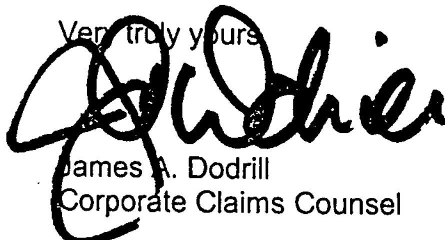
training regarding the rule occurred. While it is not clear, it is presumed such training must also be conducted annually before September 1st of each year in order to make subsequent certifications compliant with this section.

Training obviously will be a significant investment by the carriers and we can anticipate that the certification will be requested when the Commissioner is considering fining a carrier as now permitted by the Code. Given that a finding of a general business practice of violations of the Act or the Rule could result in a fine payable to the State of up to $250,000.00, insurers have already been presented with a significant incentive to upgrade training to any adjusters who handle West Virginia claims to demonstrate appropriate education in an effort to thwart any finding of a general business practice of violating the Act or the Rule. This may be somewhat problematic for carriers who operate in a centralized environment or out-of-state location.

Conclusion

Overall, we believe that the proposed changes to the rules are too restrictive, need significant clarification as to their application and are incongruent with claim handling in today's environment. We ask that you consider the foregoing as you proceed through the rule-making process and that you implement the changes/amendments we have suggested. If you would like to discuss this matter further, please do not hesitate to contact me.

Very truly yours,



James A. Dodrill
Corporate Claims Counsel

JAD/jgh

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #4

- Government Employees Insurance Company
- GEICO General Insurance Company
- GEICO Indemnity Company
- GEICO Casualty Company

One GEICO Plaza ■ Washington, DC 20076-0001

July 21, 2005

EXPRESS MAIL

RECEIVED
JUL 22 2005
WVIC LEGAL DIVISION

Victor Mullins, Esquire
Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
1124 Smith Street, Rm 309
Charleston, West Virginia 25305-0540

Re: Proposed 114 CSR 14 – Claims Handling

Dear Mr. Mullins:

Please note the following comments of the GEICO group of companies to the above-referenced proposed regulation:

§114-14-3.1 – The proposed rule provides that all communications, whether written or oral, must be dated by the insurer.

> It is unclear what is intended in applying the proposed rule to oral communications.

§114-14-4.1 – The proposed rule requires insurers to "assist the insured in determining the extent of the insurer's additional liability."

> The proposed rule goes far beyond the original rule language requiring policy disclosure and requires insurers to engage in analysis and the rendering of inappropriate legal and other advice to insureds.

§114-14-4.4 – The proposed rule prohibits any limitation on when a first-party claim may be made in the absence of a contractual requirement.

> The rule should clarify that it does not modify any applicable statute of limitations.

§114-14-4.5 – The proposed rule requires that payments and offers of settlement must "include all amounts which should be included according to the claim filed by the claimant and investigated by the insurer."

> It is unclear what is intended by this provision.

§114-14-5.1 – The proposed rule reduces from 15 to 10 working days the time in which an insurer must acknowledge a claim.

This reduction in time places an undue burden and expense on insurers, which will ultimately be borne by consumers, while providing no significant benefit to consumers.

§114-14-5.2 – The proposed rule reduces from 15 to 10 working days the time in which an insurer must respond to a departmental inquiry and changes the trigger date from the date of receipt by the insurer to the date on the inquiry.

In most cases, the proposed rule will have the effect of cutting in half the time insurers have to respond. Typically, no meaningful or adequate response may be made in this time frame. Insurers will be forced to constantly seek informal extensions or to provide responses which are not meaningful or productive.

This reduction in time places an undue burden and expense on insurers, which will ultimately be borne by consumers, while providing no significant benefit.

Insurers have no control over the date placed on the inquiry – which may be several days before it is actually mailed.

A more appropriate rule would maintain the current time for insurer responses. If the response time is to be tied to the date of the inquiry, the time should be enlarged to account for the time in transit and tied to the date of mailing (e.g., "18 days from the date the inquiry is mailed").

§114-14-6.5 – The proposed rule provides that insurers are prohibited from "making a settlement offer that is unreasonably low" and identifies factors to be used by the Commissioner in making a determination whether an offer was "unreasonably low."

The criteria set forth go far beyond any standard of good faith and place the Commissioner in the position of second-guessing not only the insurer's business judgment, but also the insurer's legal and factual analysis of the claim.

The vague criteria for reasonableness will make any decision by the Commissioner under the proposed rule inherently arbitrary.

In establishing criteria based upon the extent to which the insurer considered various factors, the proposed rule ties itself to establishing the thought process of the adjuster in making an offer. In many, if not all, cases the adjuster's recollection of his weighing of each of the identified factors in making an offer at

some point in the distant past is going to be a frustrating undertaking for all concerned.

Determining the advice of counsel considered by the insurer in making an offer would typically violate the attorney-client privilege.

§114-14-6.12 – The proposed rule provides that insurers "remain responsible for the accuracy of the data they use" to establish the value of claims.

It is unclear what is meant by "data" in this context.

The proposed rule places a heavy and unilateral burden on insurers to be correct in each and every consideration made in valuing a claim.

A more appropriate standard would be to prohibit insurers from utilizing information which they know to be inaccurate or with willful disregard for its accuracy.

§114-14-6.22 – The proposed rule prohibits insurers from deducting expenses from subrogation recoveries unless outside counsel or a collection agency is retained.

The inability of insurers to recover costs where they have utilized less expensive in-house resources will discourage the use of those resources and ultimately be reflected in increased premiums.

§114-14-8.2 – The proposed rule provides that an insurer who has a good faith belief that it is not liable for the payment must advise a third-party claimant in writing within 10 working days of receipt of the notice of claim – providing the claimant with specified information and setting for the reasons for denying the claim. Within 10 working days of acknowledging the claim or receipt of information requested when acknowledging the claim, the insurer must request any additional information necessary to process the claim (Id.).

The time periods set forth in the proposed rule are inadequate. More time is required to investigate the claim and determine whether the claim should be paid or denied and what, if any, additional information may be necessary to adjust the claim. In many cases, insurers will be forced to deny a claim due to insufficient proof of liability or damages, when a longer response time would have allowed payment of the claim following a completed investigation. The abbreviated time frame will result in a substantial and needless increase in the denial of claims.

§114-14-9 – The proposed rule provides that the Commissioner shall make determinations of administrative complaints under the regulation based upon a finding of

the reasonableness of the insurer's response to any offers to correct the alleged unfair claims settlement practice.

> No standards for what is "reasonable" are provided. The proposed rule requires the Commissioner to second-guess the insurer's business and legal judgments.
>
> Without standards for reasonableness, any decision made by the Commissioner would be inherently arbitrary.
>
> Paradoxically, under the proposed rule an insurer may be found to have committed an unfair claims settlement practice by failing to settle an underlying unfair settlement practice claim which had no actual validity.

Please contact me if you or your staff has questions regarding GEICO's position on this issue or any other legislative or regulatory matters. Thank you for your consideration.

Sincerely,

John A. Taylor
Counsel

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #5

GOLDEN RULE INSURANCE COMPANY

7440 Woodland Drive, Indianapolis, Indiana 46278

FAX

Date: 7/23/05

Number of pages including cover sheet:

To: Victor Mullins

Phone:

Fax phone: 304-558-1362

CC:

From: Katy Gilberg Government Relations

Phone: 317-297-4123

Fax phone: 317-290-8517

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

Regarding Unfair Trade Practices Title 114, Series 14

This cover sheet and the materials enclosed with this transmission are the private, confidential property of the sender, and the materials are privileged communications intended solely for the receipt, use, benefit, and information of the intended recipient indicated above. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying, distribution, or the taking of any other action in reliance on the contents of this transmission is strictly prohibited and may result in legal liability on your part. This communication may be the subject of a legal privilege. Receipt by anyone other than the intended recipient shall not be a waiver of any privilege. If you have received this transmission in error, please notify us immediately at the above telephone number and arrange for return of this transaction to us.

OPERATOR'S NAME: ______

Golden Rule®

July 23, 2005

Victor Mullins
Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540

Dear Mr. Mullins:

Thank you for the opportunity to comment on the proposed changes to the Unfair Trade Practices rule, Title 114, Series 14.

I understand that changes to this rule were necessary based on the passage of SB 418. However, it seems that several of the changes throughout the rule are arbitrary. These include:

- 114- 14-5.2 – Changes the requirement from an insurer responding to an inquiry from the Insurance Commission within 15 working days of receipt of the inquiry to responding to the same inquiry within 10 working days of the date appearing on the inquiry. Not only is the time frame being shortened, but the time begins tolling at an earlier date as well
- 114-14-6.2 – Shortens time frame to begin an investigation of a claim from 15 working days after receipt of claim to 10 working days after receipt of claim.

We continue to have other concerns and questions with this rule as well. However, I recognize this is the first draft and hope that you will continue to work with the industry as you develop this rule.

Thank you for your consideration.

Sincerely,

Katy A. Gilberg
Government Relations

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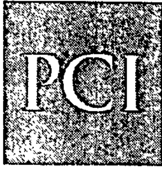
TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #6



Property Casualty Insurers
Association of America

Shaping the Future of American Insurance

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WVIC LEGAL DIVISION

Victor Mullins
Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540

RE: Proposed Administrative Rules, Title 114, Series 14, Unfair Trade Practices

Dear Mr. Mullins,

The following comments are being provided on behalf of the member companies of the Property Casualty Insurers Association of America (PCI). PCI is a national property casualty trade association comprised of more than 1,000 member companies, representing the broadest cross-section of insurers of any national trade association. PCI members write $154 billion in annual premium, or 38 percent of the nation's property/casualty insurance. In West Virginia, PCI member companies write over 33 percent of the personal lines market, and nearly 30 percent of the commercial lines market.

PCI member companies have significant concerns with respect to the proposed Rule. The proposal appears inconsistent with the intent of SB 418, does not distinguish between first party contractual relationships and third party relationships, and would impose significant burdens upon insurers without adding value to claimants.

Our specific concerns include the following:

Section 2.14

"Egregious act" is defined to include conduct that is "irresponsible" Irresponsible conduct, however, is merely negligence, and doe not imply an intentional act. It is inappropriate to include "irresponsible" conduct with fraudulent, malicious, or reckless actions. Further, as irresponsible actions are considered "negligence," inclusion of "irresponsible" conduct as an "egregious act" is inconsistent with the second part of the definition that states that simple negligence is *not* an "egregious act."

Section 4.1

This Section would require insurers to disclose to a first party claimant or beneficiary all benefits, coverages, time limits or other provisions of any insurance policy issued by an insurer that may apply to the claim presented by the claimant. This proposal, however, contradicts existing law. The Supreme Court of Appeals of West Virginia stated in Kronjaeger v, Buckeye Union Insurance Co., "[l]ooking at our own precedent, we can find no authority requiring an insurer to notify its insured of available coverage following notification of a loss or to advise its insured as

to the limits of such coverage."

Further, the level of disclosure that appears to be required by this Section could place insurers in the inappropriate position of rendering legal advice to insureds.

This Section appears to primarily apply to first party claims. If the intent is to address first party claims only, then the words "or beneficiary" should be deleted. Application of this Section to third party claims is clearly problematic, as applicable coverages may not be clear when the facts of the loss are first presented. Further, this provision would require an insurer to disclose policy limits, a practice that may subject the insured to additional or exaggerated claims.

It is also unclear how, or by what process, disclosures must be made.

Section 4.4

This Section states that, absent a deadline in the contract, that a claim may never be considered "late." This Section would contradict approved policy provisions now in place that impose reasonable time frames without specific limitations. Providing that no claim may be "late" also sets up an invitation for fraud. Without reasonable limitation on submission of claims, the insurer may lose the ability to adequately investigate certain claims.

Additionally, this provision could be interpreted to amend any existing statute of limitations.

Section 4.5

This Section would provide that the insurer is guilty of misrepresentation if any partial payments were made without an explanation as to why full amounts weren't paid. This Section offers no real consumer protection, and appears to be intended only to find cases of "misrepresentation." Very often, partial payments are made to cover the immediate need of the claimant. For example, additional living expenses following a fire loss may represent an immediate need. Time lost in creating appropriate disclosures or determining "all amounts" that may be paid, could result in significant hardship for the consumer. We suggest that this Section be deleted from the Rule.

Section 5.1

This is the first of several Sections that would reduce the time frame for acknowledgement of a claim from 15 working days to 10 working days. PCI strongly urges the Insurance Commission not to reduce the timeframe relevant to this Section, (or to Sections 5.2, 5.3, 5.4, 6.2, 6.3, 6.7, and 8.2). Reform legislation enacted this year did not impose any such requirement upon insurers. Further, the 10-day notice requirement proposed could prove burdensome to insurers in many situations. For example, delays originating in the agent's office (such as when a call is considered only an inquiry from the insured and not immediately identified as a claim) could result in delayed notice to the insurer. Further, the short time frame could be used against the insured in order for a claimant or their attorney to allege bad faith. A claim need only be filed late before a holiday weekend and intentionally misrouted as a method of "running down the clock."

The majority of states allow 15 to 30 days for acknowledgement of claims. There appears no reason for West Virginia to take a harsher approach than other states.

Section 5.2

Again, we find the reduced time frame for responding to inquiries from the Commission to be overly burdensome. Some inquiries require complex investigation of facts, or even historical recreations of policies. Insurance company staff may simply not always be able to complete a thorough investigation within 10 days.

Further, the revised Rule would start the clock from the date of the inquiry, and not the date that the insurer received the inquiry. The insurer, however, has no control over mailing time and could, conceivably, receive the inquiry with far fewer than 10 days to respond.

Section 6.2 and 6.3

Read together, these two Sections would appear to impose a maximum time frame to complete investigation of a claim. We ask the Insurance Commission to clarify the intent of the two Sections together.

Further, it is unclear if Section 6.2 applies to both first and third party claimants and should be clarified on this point.

Section 6.4

This proposed changes to this Section would require claims to be calculated in the same manner for both first party and third party claims. This requirement may actually run contrary to law. Typically, the duties owed to a third party are dictated by common law principles, while first party claims are more directly spelled out by contract. Further, the insurer owes each claimant a duty to fairly investigate and settle the claim. Where claims and the circumstances surrounding those claims differ, so might the settlement.

Existing Section 6.4 (Deleted)

Existing Section 6.4 (proposed to be deleted from the Rule), allowed insurers to deny a claim in methods other than writing with appropriate notation retained in the claim file. We urge the Insurance Commission to reinstate that provision, as it allowed simple denials to be handled very quickly, without incurring additional expense. Often such phone denials allowed an insurer to avoid opening a formal claim file, incurring loss adjustment expense, and reporting the incident as a "claim" against the insured's record.

Further, if all denials are required in writing, the Insurance Commission should clarify whether or not all inquiries regarding coverage should be considered as "claims" so that the appropriate paper denial could be generated. We believe that this is not the Insurance Commission's intent, but, by striking existing Section 6.4, that clarification becomes necessary.

Section 6.5

This Section seeks to establish guidelines for the Commissioner to evaluate whether or not an offer was unreasonably low. Many insurers rely on claims handling tools that may be proprietary in nature. This provision should clearly provide that any such tools, when disclosed to the Commission, shall remain confidential and not open to public disclosure, including disclosure to the claimant or claimant's attorney.

Further, it is unclear how the Commissioner will determine the adequacy of a settlement offer. We are concerned that this Section establishes a procedure that may be very subjective, and could easily second-guess the claims adjuster who had first hand knowledge of the facts of the claim.

Section 6.10

This new Section is confusing in that it is unclear if the insurer must provide an explanation if disclaiming coverage, if disclaiming liability, or both.

Section 6.12a

This Section would make insurers responsible for the accuracy of data contained in a computerized database or obtained by third party vendors. It is unclear how insurers are to measure the accuracy of information. What standards will the data be compared to? Database programs offer fair and consistent methods for evaluation claims – a clear benefit to the claimant. Under this proposal, however, any error in the database, no matter how small or immaterial, could result in a finding of "inaccuracy" that violates the rule. Instead, we suggest that an insurer should simply be prohibited from using information that it knows to be inaccurate.

Section 6.22

This Section would prohibit insurers from deducting expenses from subrogation recoveries unless the insurer retains outside counsel or the services of a collection agency. This provision may actually work to encourage insurers to obtain these more expensive third-party resources, as insurers will no longer be able to recover the costs of traditionally less expensive in-house resources. We recommend that the Rule be amended to allow deduction for actual expenses incurred, regardless of the source of those expenses.

Section 8.2

As stated earlier in our comments, the timeframes for investigating the claim provided here are insufficient. Often a longer response time is needed to gather additional information that may help determine whether or not a claim should truly be denied. The 10-day notice requirement could easily result in inadequate investigations and additional complaints from claimants.

This Section would also require the insurer, upon denial of a claim, to provide third party with specific information, including policy number. This Section should be amended to require the claim number instead of policy number. With respect to the third party, the policy number is not relevant.

Section 8.2b

This Section would require the insurer to provide extensive detailed information to the third party claimant. This information may not be relevant in many claims, including routine auto property damage claims. The amount of information required by this Section would slow down the settlement process and add costs for the insurer while providing no added benefit to the claimant. We request that the Insurance Commission delete this requirement as unnecessary to the process.

Section 9-1

This Section establishes procedure for administrative complaint handling. The proposed Rule states that the 45-day period begins upon receipt of the notice. This is inconsistent with the provisions of Section 5.2, where the (proposed10-day) period for handling an inquiry from the Insurance Commission runs from the date of the inquiry. We suggest that, for clarity, the Rules follow a consistent standard throughout.

Section 9-2

This Section provides that a hearing would be triggered when "an offer should have been made" or when the final offer "may have been unreasonable." However, there is no clear definition of what constitutes "reasonable," leaving this determination open to the discretion of the Insurance Commission and the possibility that such determination may be subjective or inconsistent with other decisions.

Further, the newly enacted law provides that a dispute regarding the value of a claim does *not* constitute "bad faith" and, therefore, should not result in a hearing.

We appreciate the opportunity to provide comment on the proposed Rule, but urge the Insurance Commission to make substantial changes to the proposal. In its current form, the proposal does not take into account the variety of circumstances that may surround a claim, the inconvenience and additional expense to all parties that result from additional unnecessary paperwork, and the difficulties with complying with standards that may be subjective or unclear. Most importantly, we ask that the Insurance Commission not impose standards that would act to negate the positive reforms enacted the year by the Legislature.

Very Truly Yours,

Lynn Knauf
Director –Personal Lines
PCI

Copy to: The Honorable Jane L. Cline
Mary Jane Pickens

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #7

State Farm®
Providing Insurance and Financial Services
Home Office, Bloomington, Illinois 61710

COPY

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JUL 22 2005
WVIC LEGAL DIVISION

July 22, 2005

Mr. Victor Mullins, Associate Counsel
West Virginia Insurance Commission
Post Office Box 50540
Charleston, WV 25305-0540

RE: Comments Regarding Proposed Amendments to Unfair Trade Practices Legislative Rules -- 114 CSR 14

Dear Mr. Mullins:

On behalf of the State Farm Insurance Companies, please accept these written comments regarding the proposed amendments to the Unfair Trade Practice rules at 114 CSR 14.

In general, State Farm strongly objects to the numerous changes proposed as amendments to 114 CSR 14. The proposed changes deviate substantially from the National Association of Insurance Commissioners' Unfair Property/Casualty Claims Settlement Practices model regulation (upon which the current West Virginia rules are based). The West Virginia Legislature passed several pieces of reform legislation during the 2005 session with the intent of making West Virginia's insurance laws more consistent and more mainstream when compared to other states. Unfortunately, the proposed amendments would have the opposite effect; making West Virginia's administrative rules unique and burdensome as compared to other states.

The use of undefined, vague and ambiguous words and phrases throughout these amendments will invite a flood of meritless and unproductive third-party administrative complaints and first-party lawsuits. Examples of such words and phrases include, but are not limited to, "unreasonably low", "irresponsible", "simple negligence", "unreasonably delay", "completion", "not reasonably required", and "whether an offer should have been made". Moreover, the definition of the word "egregious" appears to be contrary to its common English language definition. According to Webster's Dictionary, the common definition of

the word "egregious" is "outstanding for undesirable qualities; remarkably bad; flagrant." The inclusion of words such as "irresponsible" and "reckless" in the proposed regulation's definition of the word "egregious" are not in keeping with the common English language definition of the word.

Enactment of these proposed amendments would result in West Virginia's Unfair Trade Practice rules becoming among the most onerous and burdensome rules in the nation. The numerous time deadline changes from 15 working days down to 10 working days proposed in several amendments are not required by any statute or by any of the recent insurance reform legislation, nor are they consistent with the NAIC Model rules. For example, the model NAIC regulation requires insurer to acknowledge the receipt of a claim within 15 days and to respond to inquiries from the insurance department within 21 days. Furthermore, the proposed definition of "complete written response" in section 5.2 indicates that responses must include copies of claim files upon request. We are unaware of any statutory authority that would require insurers to submit complete copies of claim files to the Department of Insurance. The closest statutory authority appears in WV Code 33-2-9(i)(2), which requires insurers to provide "timely, convenient and free access at all reasonable hours <u>at its offices</u> to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined." While we do not object to reasonable document requests in the context of a legitimate complaint investigation, we contend that insurers are required to provide access to the complete claim files only during reasonable hours at the offices where the files are regularly maintained.

The amendments to section 114-14-6 of the proposed regulation differ substantially from the NAIC model regulations. These amendments adopt definitions such as "unreasonably low offers," impose new notice requirements on insurers, assign responsibility to insurers for the accuracy of data sources, prohibit insurers from deducting premiums owed from claim settlements, limit documents that insurers may request from claimant and prohibit the use of truth detection devices. Without commenting on whether or not these provisions are desirable or appropriate, we question the Department's statutory authority to impose these burdensome requirements. Nothing in the recently enacted insurance reform legislation suggests that the West Virginia Legislature anticipated the imposition of these significant limitations and burdens on insurers.

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The proposed amendments to section 114-14-8 would impose duties and obligations on insurers towards third-party claimants which equal or exceed the contractual duties and obligations owed by insurers to our own first-party insured policyholders. This result is clearly contrary to established case law from the West Virginia Supreme Court regarding the duties an insurer owes to its own insured policyholders versus the duties it owes to third parties who lack any contractual relationship with the insurer. The law is well settled that an insurer owes a higher duty towards its own insured with whom it has a contractual relationship than it owes to a third party claimant. The proposed amendments destroy this distinction and seek to impose higher duties than those required by statute or case law.

The proposed addition of section 114-14-10 regarding the training of claim adjusters is wholly unnecessary. The duties that insurers owe to their policyholders and third-party claimants are determined by the statutory and case law of West Virginia. Those duties are owed and will continue to be owed by insurers whether or not section 114-14-10 is adopted by the Department. Therefore, the adoption of this burdensome section is merely an added regulatory cost that does nothing to further the aims of the recently enacted insurance reforms. Moreover, had the Legislature wished to impose specific continuing education requirements of this nature, then it is could have specifically imposed those requirements as it has done in the case of insurance agents.

The effect of the proposed amendments would also threaten many of the benefits and savings achieved as a result of the reforms enacted by the West Virginia Legislature during the 2005 session. State Farm believes that the impact of the proposed amendments would be contrary to the intent of the legislative reforms signed into law by Governor Manchin earlier this year, and could jeopardize the recent rate reductions implemented by insurers as well as future rate reductions, to the detriment of West Virginia consumers. For example, the shorter 10 day time deadlines will necessitate that many insurers hire additional staff in order to handle the volume of claims -- with such increased costs negating any possible savings resulting from the recent legislative reforms.

I have attached a copy of the NAIC Unfair Property/Casualty Clams Settlement Practices model regulation with this letter. The current West Virginia rules are based on this NAIC model. Given that the West Virginia Legislature has chosen to join the vast majority of other states in prohibiting private causes of action for third party bad faith, we would strongly encourage the Department to revise the existing Unfair Trade Practices regulation to more closely mirror the NAIC model

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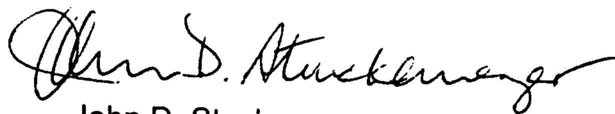
regulations that have also been adopted by the majority of other states. As currently proposed, the draft regulations are a radical departure from the NAIC model that will serve only to further confuse the claim adjustment process and add unnecessary expense. We respectfully submit that to adopt the regulations as proposed would frustrate the intent of Governor Manchin and the West Virginia Legislature as expressed in the enactment of Senate Bills 30, 418 and 421.

We strongly recommend that you replace the existing Unfair Trade Practices rules with the model NAIC Unfair Property/Casualty Clams Settlement Practices regulations, making only those additions that are necessary to administer the new third party administrative complaint process.

Finally, State Farm has participated as a member of the West Virginia Insurance Federation in drafting numerous specific comments and suggestions regarding these rules and proposed amendments. State Farm is a member of the West Virginia Insurance Federation, which is the state trade association representing property and casualty insurers doing business in West Virginia. The written comments offered by the West Virginia Insurance Federation are being submitted to you via separate letter by the Federation's Executive Director, Jill Bentz. By reference, State Farm also adopts and supports the written comments being submitted by the West Virginia Insurance Federation concerning these rules and the proposed amendments.

Sincerely,



John D. Stuckemeyer
Counsel
STATE FARM INSURANCE COMPANIES

COPY

Attachment /

cc: Commissioner Jane Cline
Deputy Commissioner Bill Kenny
General Counsel Mary Jane Pickens

Governor Joe Manchin III
Legislative Director Jim Pitrolo
Public Policy Director Brian Kastick

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

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Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of property and casualty claims arising under contracts or certificates issued to residents of the State. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create nor imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate any change of position.

Drafting Note: Any jurisdiction which may choose to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has separately promulgated an Unfair Life, Accident and Health Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

B. "Claim file" means any retrievable electronic file, paper file or combination of both;

C. "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

D. "Days" means calendar days;

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E. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

F. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

G. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.

I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

J. "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

K. "Written communications" includes all correspondence, regardless of source or type, that is materially related to the handling of the claim.

Section 4. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by the Commissioner's duly appointed designees. To aid in such examination:

A. The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.

B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

C. Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.

D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Section 5. Misrepresentation of Policy Provisions

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

C. A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions in the claim file.

D. No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition, or claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

E. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

F. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Section 6. Failure to Acknowledge Pertinent Communications

A. Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

B. Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within twenty-one (21) days of receipt of such inquiry, furnish the department with an adequate response to the inquiry in duplicate.

C. An appropriate reply shall be made within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within fifteen (15) days of notification of a claim shall constitute compliance with Subsection A of this section.

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Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

A. Within twenty-one (21) days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by Section 4.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

B. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within twenty-one (21) days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

C. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

D. No insurer shall continue negotiations for settlement of a claim directly with a claimant who is not legally represented, if the claimant's rights may be affected by a statute of limitations, unless the insurer has given the claimant written notice of such limitation. Notice shall be given to first party claimants at least thirty (30) days and to third party claimants at least sixty (60) days before the date on which such time limit may expire.

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

F. The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute and where the payee is known should be tendered within thirty (30) days if such payment would terminate the insurer's known liability under that individual coverage.

G. No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

H. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

A. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

(a) The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or

(b) The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to Subparagraph (a); or

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(c) One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to (a) and (b) above; or

(d) Any source for determining statistically valid fair market values that meet all of the following criteria:

(i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years taking into account the values of all major options for such vehicles; and

(iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.

(e) Right of Recourse—If the insurer is notified within thirty-five (35) days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for the market value, the company shall reopen its claim file and the following procedures shall apply:

(i) The company may locate a comparable vehicle by the same manufacturer, same year, similar body style and similar options and price range for the insured for the market value determined by the company at the time of settlement. Any such vehicle must be available through licensed dealers;

(ii) The company shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;

(iii) The company may elect to offer a replacement in accordance with the provisions set forth in Section 8A(1); or

(iv) The company may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The company is not required to take action under this subsection if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same year, similar body style and similar options in as good or better condition as the total loss vehicle which could have been purchased for the market value determined by the company before applicable deductions. The documentation shall include the vehicle identification number.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in Subsection A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for the settlement shall be fully explained to the first party claimant.

B. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy.

C. Insurers shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

D. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

E. Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which he obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repairers, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications.

F. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

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G. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

H. Storage and Towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges and documentation of the denial as required by Section 4. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured.

I. Betterment deductions are allowable only if the deductions:

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

(b) Reflect the general overall condition of the vehicle, considering its age, for either or both:

(i) The wear and tear or rust, limited to no more than a deduction of $1,000;

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

(2) Any deductions set forth in (1)(a) or (b) above must be measurable, itemized, specified as to dollar amount and documented in the claim file.

(3) No insurer shall require the insured or claimant to supply parts for replacement.

J. Replacement Crash Parts

(1) Purpose

The purpose of this subsection is to set forth standards for the prompt, fair and equitable settlements applicable to automobile insurance with regard to the use of replacement crash parts. It is intended to regulate the use of replacement crash parts in automobile damage repairs which insurers pay for on their insured's vehicle. It also requires that all replacement crash parts, as defined in this section, be identified and be of the same quality as the original part.

(2) "Replacement crash part," for purposes of this regulation, means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

(3) Identification

All replacement crash parts, which are subject to this section and manufactured after the effective date of this section, shall carry sufficient permanent non-removable identification so as to identify its manufacturer. Such identification shall be accessible to the extent possible after installation.

(4) Like Kind and Quality

No insurer shall require the use of replacement crash parts in the repair of an automobile unless the replacement crash part is at least equal in kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of replacement crash parts shall consider the cost of any modifications which may become necessary when making the repair.

Drafting Note: Subsection J incorporates the fundamental provisions of the NAIC 1987 "After Market Parts Model Regulation" and makes requirements applicable to all replacement crash parts. Adoption of this subsection is the recommended approach.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

A. When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

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

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

B. Actual Cash Value:

(1) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.

(2) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is

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not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Legislative History (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 179-184 (adopted).
1991 Proc. I 9, 16, 192-193, 206-211 (amended and reprinted).

This document replaces a model named "Unfair Claims Settlement Practices Model Regulation."

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).
1980 Proc. II 22, 26, 906, 930, 936 (amended).
1981 Proc. I 47, 51, 255, 258, 263 (amended).

UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

The date in parentheses is the effective date of the legislation or regulation, with latest amendments. This is a combined listing of state adoptions dealing with property/casualty and life, accident and health claims. See the KEY at the end of the listing.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA INS. DEPT. REG. ch. 482-1-124 (2003) [3*]; ch. 482-1-125 (2003/2004) [2*]	
Alaska	ALASKA ADMIN. CODE tit. 3 §§ 26.010 to 26.300 (1989/2004) [1, 2, 3]	
Arizona	ARIZ. ADMIN. COMP. R20-6-801 (1981) [1]	
Arkansas	ARK. INS. RULE & REG. 43 (1989/2001) [1, 2, 3]	
California		CAL. ADMIN. CODE tit. 10 §§ 2695.1 to 2695.13 (partially based on model) (1993/2005) [2]
Colorado		COLO. ADMIN. INS. REG. 5-1-14 (2001); *See also* 5-2-15 (2004) [2]
Connecticut	NO ACTION TO DATE	
Delaware		DEL. ADMIN. CODE tit. 18 § 903 (2001/2003); § 1310 (1998/2003) [3]
District of Columbia	NO ACTION TO DATE	
Florida	FLA. ADMIN. CODE §§ 69O-166.021 to 69O-166.031 (1992/2004).	FLA. STAT. §§ 626.9743 to 626.9744 (2004); FLA. ADMIN. CODE §§ 69O-220.001 to 69O-220.201 (1993) (Code of Ethics-Insurance Adjusters).
Georgia		GA. ADMIN. COMP. ch. 120-2-52 (1993) [2]
Guam	NO ACTION TO DATE	

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Hawaii	NO ACTION TO DATE	
Idaho	NO ACTION TO DATE	
Illinois		ILL. ADMIN. REG. tit. 50 §§ 919.10 to 919.100 (1974/2004) [2, 3]
Indiana	NO ACTION TO DATE	
Iowa	NO ACTION TO DATE	
Kansas	KAN. ADMIN. REGS. §§ 40-1-34 (1981/2003) (Adopts 1981 edition of regulation by reference with some variation) [1, 2]	
Kentucky	806 KY. ADMIN. REGS. 12:095 (1992/2001) [2*]; 806 KY. ADMIN.REGS. 12:092 (1990) [3*]	
Louisiana	NO ACTION TO DATE	
Maine	NO ACTION TO DATE	
Maryland		MD. ANN. CODE INS. § 27-304.1 (2003) (Authorizes commissioner to adopt rules about claims involing a total loss of auto); MD. ADMIN. CODE tit. 9 subtit. 30 ch. 76 §§ .01 to .07 (1989/1993).
Massachusetts	NO ACTION TO DATE	
Michigan	NO ACTION TO DATE	
Minnesota		MINN. STAT. § 72A.201 (1967/1989) [2]
Mississippi	NO ACTION TO DATE	
Missouri	MO. ADMIN. CODE tit. 20 §§ 100-1.010 to 100-1.300 (1974/2003) [1, 2]	

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Montana	NO ACTION TO DATE	
Nebraska	NEB. ADMIN. R. tit. 210 ch. 60 (1992/1994) [2*]; tit. 210 ch. 61 (1992/1994) [3*]	
Nevada	NEV. ADMIN. CODE §§ 686A.600 to 686A.680 (1980/1992) [1, 2]	
New Hampshire		N.H. ADMIN. CODE §§ INS. 1001.01 to 1001.16 (1982/1999).
New Jersey	N.J. ADMIN. CODE §§ 11:2-17.1 to 11:2-17.14 (1981/2003) [1, 2, 3]	
New Mexico	NO ACTION TO DATE	
New York	N.Y. ADMIN. CODE tit. 11 §§ 216.0 to 216.7 (Regulation 64) (1972/2003) (model and much more) [1, 2]	
North Carolina		N.C. ADMIN. CODE tit. 11 ch. 4 § .0319 (1979) [3]; §§.0418 to .0428 (1979/1989) [2]
North Dakota	NO ACTION TO DATE	
Northern Marianas	NO ACTION TO DATE	
Ohio	OHIO ADMIN. CODE § 3901-1-54 (1993/2004) [2*]	OHIO ADMIN. CODE § 3901-1-60 (1994) (Health claims).
Oklahoma	OKLA. ADMIN. CODE §§ 365:15-3-1 to 365:15-3-9 (1989/1994) [1, 2]	
Oregon	OR. ADMIN. R. §§ 836-080-0205 to 836-080-0250 (1980/1992) [1, 2]	
Pennsylvania	PA. ADMIN. CODE tit. 31 §§ 146.1 to 146.10 (1978) [1, 2]	
Puerto Rico		P.R. R. RULE XLVII (1975).
Rhode Island	R.I. REGS. R27-73-001 to 27-73-011 (1994) [2*]	*See also* Bulletin 2004-3 (2004).

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
South Carolina	NO ACTION TO DATE	
South Dakota	NO ACTION TO DATE	
Tennessee	NO ACTION TO DATE	
Texas		TEX. ADMIN. REGS. §§ 21.201 to 21.205 (1976/1998); 21.2801 to 21.2816 (2000).
Utah	UTAH INS. DEPT. R590-89 (1982/1989) [1, 2]; UTAH INS. DEPT. R590-190 (1999) [2*]; R590-191 (1999), R590-192 (1999) [3*]	
Vermont	VT. ADMIN. COMP. INS. DEPT. R. 79-2 (1979) [1, 2]	
Virgin Islands	NO ACTION TO DATE	
Virginia	14 VA. ADMIN. CODE 5-400-10 to 5-400-80 (1978) [1, 2]	
Washington	WASH. ADMIN. CODE R. §§ 284-30-300 to 284-30-800 (1978/2003) (Model and more) [1, 2, 3]	
West Virginia	W. VA. REGS. §§ 114-14-1 to 114-14-9 (1981/2003) [1, 2]	
Wisconsin	NO ACTION TO DATE	
Wyoming	NO ACTION TO DATE	

KEY

[1] Adopted original claims settlement regulation. See 1976 Proc. II 367 and subsequent amendments.

[2] Contains specific provisions for property/casualty claims settlement.
* Asterisk indicates based on model found at 902-1.

[3] Contains specific provisions for life and health claims settlement.
* Asterisk indicates based on model found at 903-1.

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Legislative History
Cited to the Proceedings of the NAIC

After a section was added to the Unfair Trade Practices Act defining unfair claims settlement practices, the subcommittee began work on a regulation. **1975 Proc. II 319.**

It was the consensus of the drafters working on the new regulation that the new drafts would provide a new emphasis on claims issues. **1990 Proc. II 160.**

Section 1. Authority

Section 2. Purpose

In 1988 a new subgroup was appointed to revisit the Unfair Claims Settlement Practices Regulation. Several regulators discussed the need to address the regulation in light of the emerging growth of private causes of action under the comparable state provisions and whether the actions were appropriate and beneficial to consumers in general. **1989 Proc. I 159.**

Two drafts were offered based on the existing model. The drafts were separated into one covering life and health claims and one covering property and casualty claims. The first issue of discussion was the NAIC's position regarding whether a private cause of action was intended to be created by the Unfair Trade Practices Act and the corresponding regulation. The subgroup decided no private cause of action was intended and language was added to the proposed drafts to that effect. **1989 Proc. II 204.**

The last sentence stating this was a clarification of original intent rather than a change of position was added with the technical amendments six months after adoption of the new model. **1991 Proc. IA 206.**

Section 3. Definitions

Most of the definitions adopted in the original model were incorporated in the new replacement model also. **1975 Proc. II 319.**

The provision incorporating the statutory definition by reference was added with the technical amendments in December of 1990. **1991 Proc. IA 206.**

B. A definition of claim file was added with the technical amendments. **1991 Proc. IA 206.**

C. The advisory committee expressed concern about the definition of claimant which also included his legal representative. The advisory committee interpreted this to mean the claimant's attorney or someone else authorized by law to represent the claimant. They did not interpret it, for example, to include the garage owner to whom the claimant had taken his car. The garage owner has an inherent conflict of interest with the claimant. Permitting the garage owner to negotiate claims on behalf of the claimant would increase the cost of settling claims. **1976 Proc. II 371.**

F. The model recognized the distinction between first and third party claimants by definition and application. This was supported by the advisory committee. **1976 Proc. II 372.**

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Legislative History
Cited to the Proceedings of the NAIC

Section 4. File and Record Documentation

Section 5. Misrepresentation of Policy Provisions

Section 6. Failure to Acknowledge Pertinent Communications

The chair of the advisory committee presented their objections to the time frame for responding to claimants. The model originally adopted allowed ten days for response, but the advisory committee did not feel this was long enough. Since the proposed regulation was to fit all lines of insurance and all kinds of companies with varying methods of operations, they thought 15 days was a more realistic starting point. **1976 Proc. II 370.** The provision adopted continued to include the ten-day limit. **1976 Proc. II 368.**

One comment received on the draft suggested that including requirements for unnecessary correspondence, unrealistic deadlines, and inflexible guidelines would ultimately result in an increase in settlement costs. **1976 Proc. II 372.**

Section 7. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

It was suggested by one commentator that claim settlement guidelines that would be appropriate for one line might not be appropriate for another. The time needed for settling an auto claim may have little bearing on that needed for an ocean marine claim. **1976 Proc. II 372.**

When drafters were preparing the new model regulation, the advisory committee reported continuing concerns where it felt the property and casualty regulation had gone too far in the particulars of claim assessment and the payment process. **1990 Proc. II 160.**

B. The NAIC Arson Task Force spoke in favor of adoption of the model regulation by the states and particularly endorsed the provision permitting extra time for investigations. There was general agreement that the model provision permitted insurers additional periods of time to conduct investigations as long as the insured is notified at a specific interval and given reasons for the need for additional time. The model usually works well in balancing the rights of insureds with the needs of insurance companies to adequately investigate claims. **1980 Proc. I 683.**

An amendment to both Subsections B and C was adopted upon the recommendation of the Arson Task Force. Adjusters had frequently complained that the model regulation did not allow enough time for investigation. The new second paragraph allowed a longer time to investigate in cases of suspected arson, supported by specific information, such as evidence of an accelerant used in the fire. The specific information must be available for insurance department review. **1980 Proc. II 933, 936.**

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Legislative History
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Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

The first model adopted had specific provisions addressed to claims practices that had produced problems in the past, principally in the auto insurance field. **1976 Proc. II 370-371.**

E. A provision in the original model prohibited basing cash settlement on an amount less than what repairs would cost except in total loss situations. This was deleted in 1980 as incompatible with cost containment concerns. The language permitted the practice of a growing number of insurers to make a claim settlement offer based on the difference in value of the car from the time before the loss to a time directly after the loss in situations where they have good reason to believe the claimant would not have the car repaired. In almost all cases this difference in value would be less than the cost of repairing the damage and would frequently involve a situation where there already existed unrepaired damage. The subcommittee listed several advantages of this loss settlement technique: (1) Promotes cost containment on auto physical damage insurance; (2) The law of damages in most states supports a decrease in value concept; (3) Insured still has the option to have car repaired; (4) Procedure has indirectly encouraged repairing of vehicles. They also listed several disadvantages: (1) Determination of the amount of decrease is often difficult; (2) Offer often causes insureds to think they are being offered less than actual loss; (3) Procedure becomes unfair if arbitrary formulas used; (4) Hard to explain to claimants. **1981 Proc. I 262-263.**

A consumer representative expressed concern about the deletion. He described problems he felt exist in the "decrease in value" claims program. The subcommittee agreed to give consideration to his concerns. **1981 Proc. II 431.**

The subcommittee voted to reaffirm the deletion of the provision. Several insurers spoke and presented statements in support of the NAIC action. One said that the NAIC action did not imply endorsement of "decrease in value" loss settlement practices, but rather recognized currently approved policy provisions permitting alternate types of claims settlement. **1982 Proc. I 158-159.**

An association of insurers encouraged the subcommittee to retain the deletion. The representatives stated that courts in many jurisdictions used decrease in value as the measure of damage. To require settlement based on the cost of repair, regardless of whether repairs are made, will oftentimes result in the insured receiving a windfall. **1982 Proc. I 160.**

One regulator noted than certain consumer safeguards should be observed in connection with "decrease in value" claims settlement programs. The seven characteristics necessary to make such programs effective were outlined:

(1) An estimate of the decrease in value must be made by a qualified appraiser who has personally inspected the vehicle and this estimate must be given to the claimant.

(2) The estimate of the decrease in value must be based on the value of the car prior to the loss and the value of the car after the loss.

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UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Legislative History
Cited to the Proceedings of the NAIC

Section 8E (cont.)

(3) Formulas, such as percentage of repair cost, may not be used to determine the decrease in value.

(4) Settlements based on the decrease in value must contain an offer to pay the difference between the decrease in value settlement and the repair cost if the car is subsequently repaired within a reasonable period.

(5) There must be complete documentation of each decrease in value claim settlement including an explanation of how both the decrease in value and repair cost were determined and a copy of this should be given to the claimant.

(6) The decrease in value procedure should not be used in instances where vehicle damage involves safety-related equipment.

(7) The decrease in value procedure should be used uniformly and should not discriminate against first-party or third-party claimants. **1982 Proc. I 158.**

J. A drafting note was added stating that this subsection incorporates the fundamental provisions of the NAIC's After Market Parts Regulation. **1991 Proc. IA 211.**

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

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Chronological Summary of Actions

June 1976: Adopted Unfair Claims Settlement Practices Model Regulation.

June 1980: Adopted provision allowing additional time to investigate claims when arson is suspected.

December 1980: Deleted sentence which proscribed setting lower limit on settlement offers.

June 1990: Adopted new separate regulation for property and casualty claims.

December 1990: Adopted technical amendments.

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TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #8

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Sent by Electronic Mail to Victor.Mullins@wvinsurance.gov

RECEIVED
JUL 2 5 2005
WVIC LEGAL DIVISION

July 22, 2005

Victor A. Mullins, Associate Counsel,
West Virginia Insurance Commission
1124 Smith Street
Charleston, West Virginia 25301

Re: Proposed Administrative Rule, Title 114, Series 14

Dear Mr. Mullins:

I am writing today on behalf of the National Association of Mutual Insurance Companies (NAMIC) and 64 of its member companies who account for 58 percent of the automobile insurance premium written in West Virginia. NAMIC respectfully opposes the changes proposed in the above-captioned administrative rule dealing with unfair claim settlement practices.

Rather than repeat the very detailed arguments offered by the West Virginia Insurance Federation (WVIF) in its submission, NAMIC, as an associate member of that organization, simply wishes to be on record with the Insurance Commission in wholeheartedly supporting the WVIF submission.

However, I would like to offer two observations not entirely covered by the WVIF. First, it seems logical to presume the Insurance Commission staff must feel some pressure in assuming the added regulatory oversight of claims payments that will come as a consequence of Senate Bill 418. Elimination of a private cause of action was a hard fought legislative battle, and those who oppose its loss, will be quick to criticize the Insurance Commission if they perceive that the Commission staff is shirking its duty to ensure that insurers are paying claims fairly and equitably. But to confront this criticism by shortening the time deadlines in the proposed rule strikes us as the wrong approach to take.

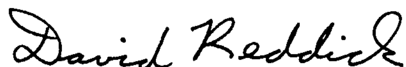
A review of other state unfair trade practice statutes shows that only a handful of states impose a 10-day timeline while the majority of states – including large states like California and Florida – allow 15 days as is the current standard in West Virginia.

As the rule-making process goes forward, NAMIC would ask the Insurance Commission to re-evalute its position on the time deadlines and to leave the current timelines in place. Rather than impose unreasonably restrictive and burdensome time frames on insurers, NAMIC believes the Insurance Commission instead should focus its attention on those few insurers who exhibit egregous behaviors by consistently denying or delaying claim payments.

My second observation deals with perception. As a representative of a national property/casualty trade association, I am asked by some of our more than 1,400 member companies to help them evaluate states where they might consider expanding their businesses. To be perfectly candid, my members previously have shown little interest in West Virginia, but with Senate Bill 418 and workers' compensation reforms being enacted this year, some members have considered giving West Virginia a second look. My question is simply this: how do I reconcile for my members the Governor's mantra that West Virginia is "open for business" again with the provisions found in the above-captioned administrative rule?

Thank you for the opportunity to offer these comments. NAMIC looks forward to working with the Insurance Commission on its proposed rule and to resolving the issues raised by this letter and the WVIF submission.

Sincerely,



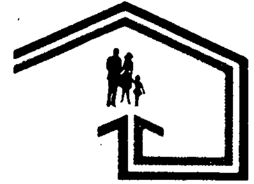
David Reddick
State Affairs Manager – Southeast Region

cc: Commissioner Jane L. Cline
Brian Kastick
Jill C, Bentz

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #9

SAFE



INSURANCE COMPANY

July 21, 2005

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

Victor Mullens, Associate Counsel
West Virginia Insurance Commission
P. O. Box 50540
Charleston, WV 25305-0540

RE: Proposed Legislative Rule change Title 114, Series 14 – Unfair Trade Practices

Dear Mr. Mullins,

Due to just recently learning of the proposed rule changes and the limited time frame in which to respond i.e., the comment period ending July 23, 2005, it is difficult to outline all of what seems to be areas needing addressed in the proposed rule changes, some of which were attempted to be resolved by recent legislation that solely and specifically addressed 3rd party issues. The proposed changes incorporate First party claims as well, which was not addressed by the legislation. Clearly if some of the phraseology in the proposed rule changes are not modified or deleted, it will create many new issues.

Initial observations:

2.14 "Egregious Act" Is a definition needed? At a minimum "irresponsible" should be taken out and "simple negligence" at least changed to negligence.

4.1 Representation of Policy Provisions and Benefits
The existing language is sufficient; insurers should not be required to comply with additional duties to create additional expense and "potential" claims.

4.4 Time Limit for notification of claim
Types of policies speak for themselves and delays in timely reporting occurrences can be prejudicial to an insurer in investigation, assessment of damages, fraud prevention, etc. Proposed language seems unnecessary.

4.5 Partial and advance payments are routinely made for the benefit of the policyholder, particularly on large losses. As written, "any payments" made that does not include "all amounts" which should be included could be construed as misrepresenting a pertinent policy provision. Vague language does not contemplate disputes on settlement value, coverage disputes on different aspects of claim etc.

Note: Sections 5.1, 5.2, 5.3, 5.4, 6.2, 6.3, 8.2, 8.3 or all time frames that changed to 10 days or less should at a minimum remain at 15 working days. There is no logical reason we can think of that warrants such a limited and restrictive time frame. Restrictive time frames can be problematic for small and large carriers alike and can make it more difficult to combat fraud. Consideration should be given to lengthening such time frames as opposed to lessening them. The time frame in which a defendant must answer a legal complaint is 20 days.(Interestingly, a time frame that did not change was "Time for payment of claims" i.e., 6.13, which is probably the easiest to comply with) Regardless, if a response is made on the 11th day instead of the 10th is it truly an UNFAIR TRADE PRACTICE., what are the damages? Shortened time frames are an unreasonable burden and of real benefit to no one.

5.1 Additional language appears to serve no purpose. Many policies generally state in the event of a claim to contact us or **our agent**.

5.2 Response time should at least remain at 15 working days of **receipt** of inquiry not "the date appearing on the inquiry". Mail service in unpredictable and we have received mail post marked multiple days before we received it or multiple days late. Insurers have no control over mail service. Further, small carriers generally have limited personnel or resources and such personnel may be attending a conference, on vacation, or for various and sundry reasons be away for several days. In addition, catastrophic occurrences are not addressed.

6.4 The last two sentences are flawed. If an insured has replacement coverage on personal or real property, the 3rd party claimant would not be entitled to same as a matter of law. 3rd party property claims are settled at Actual Cash Value not replacement cost. In addition, the same duties are not owed to a 3rd party claimant who does not pay premiums, is not a party to the insuring contract, and is not a policyholder owner of a mutual company. There would also appear to be potential Federal and State privacy issues in advising claimants the claim presented is greater than policy limits without consent from the policyholder.

6.5 Unreasonably Low Offers
Multiple concerns with this new subjective language which should be deleted or substantially modified. There is no definition of "reasonable". In addition, insurer and insured confidentiality protection is not addressed.

6.6 Denial of claims does away with 6.4 of old regulation and under the proposed rule change **every denial must be in writing.** Should such language remain, when a policyholder calls a claim department to inquire about coverage for getting a fish hook out of their finger or for bee hives in their attic, an insurer will be required to send a formal written denial, which incorporates setting up a claim file that entails additional administrative cost and unnecessary claims history for that insured etc.

6.7 "has fraudulently caused" Removing **contributed to** greatly increases the burden of proof in fraud cases and limits the industries ability to combat fraudulent claims that ultimately could result in increased cost for insurance consumers.

6.10 Coverage and liability are not one in the same. "Liability" should be changed to read coverage. Is this section addressing 1st or 3rd party claimants as liability would not be disclaimed due to policy breaches as a 3rd party claimant is not a policyholder?

6.17 If any claim is denied for any reason there are potential savings to the insurer so one is opening Pandora's Box. Profit sharing, employee bonuses, stock dividends etc. could be subject to this which likely was not the intent. Underwriters, accounting personnel, and most Agents, have nothing to do with handling claims yet can be compensated based on corporate performance.

6.20 There are several types of claims that can involve fraud (other than a fire loss) such as theft where financial records are useful and can be beneficial in combating fraud. The language is far too limiting. Financial motive is the driver behind insurance fraud. The language is also in contrast with some insuring contracts.

8.1 P & C insurance contracts do not afford coverage to 3rd parties?

8.2 Standards for Prompt, fair Equitable Settlement
A policy number is not public information and therefore would be protected under the Gramm-Leach-Bliley privacy act. A non-policyholder has no need for a policy number, only a claim number.

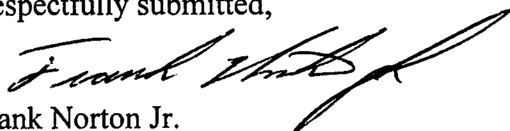
8.3 7 days?

9.1 Will an administrative complaint be received in writing? After "receiving notice" seems inconsistent with proposed rules in 5.2?

10 Training and Certification This area should be totally reconsidered and/or deleted. "Claims agent" not defined. Claims adjuster's are licensed or "certified" through the state. Do we have a duty to train Independent Adjusters? Would such expense ultimately be placed on consumers?

The aforementioned does not address all of the potential adverse effects and/or concerns regarding the proposed rule changes some of which appear unreasonable, restrictive and burdensome, but clearly demonstrates a need for reconsideration and modification of the existing proposed rule changes. I would hope that more consideration will be given to the effects that the changes would have and be reconsidered before your agency approves the filing.

Respectfully submitted,



Frank Norton Jr.
President
Safe Insurance Company
1017 6th Avenue
Huntington, WV 25721
(304) 529-2771 Ext. 15

C: Jane Cline
Insurance Commissioner

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #10

Panhandle Farmers Mutual Insurance Company
R.D. 1, Box 166A
Moundsville, WV 26041
In Business Since 1898
(304) 845-2649 Fax (304) 845-2967
www.panhandleins.com

July 22, 2005

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

WV Insurance Commission
Victor Mullins, Assoc. Counsel
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540

Regarding: Rules Proposals, Title 114, Series 14

Dear Mr. Mullins,

Careful consideration has been given to the proposed amendments to 114 CSR 14 as they related to the UTPA. We have worked closely with the WV Insurance Federation who is submitting suggested changes that more uniformly complies with filed policy language and the general workings of claims investigation. But, we did want to express our concerns over many of the proposed changes and ask that consideration be given to the suggestions being made by the Federation.

Clearly, some of the proposed changes are contrary to policy language that has been filed by the companies and approved by the WV Insurance Department Rates and Forms Division. In addition, the proposed changes would hamper the investigative processes in many situations. They would create a hindrance to the very young fraud legislation and open opportunities for fraudulent activity and civil action for violations of rules, if adopted in the Department's proposed form.

It was noted that many of the rules inappropriately distinguish between the first and third party claimants in the prospectus of duty owed to them by an insurer. We certainly propose fair and equable treatment but first and third party claimants have their own distinctions and must be handled with a significant various due to a contractual duty and relationship. The rules, as proposed, would make it impossible for a company to comply.

In addition, we feel that the proposed rule changes are contrary to the recently passed legislation relating to insurance reform that includes Senate Bill 418. Also, the restrictions on the time deadlines are too stringent for allowing adequate and appropriate time to respond. Recently, one of the domestic companies received a complaint nearly eight days after the dated inquiry. This seemingly was due partly to a long holiday weekend and the request not being mailed timely. But, with the proposed changed this company would have had less then 2 days to respond which in most cases is just not adequate to properly evaluate a file and provide requested documentation.

We sincerely hope that the proposals being submitted by the WV Insurance Federation will be given due consideration to avoid dismantling the recent progress made in the legislative session. If we can be of any help in this matter please feel free to contact my office.

Sincerely,

Art Meadows, President/CEO
Chairman – WV Insurance Federation

cc: Jane Cline, WV Insurance Commissioner
cc: Mary Jane Pickens, Director of Legal Division

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #11

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

Direct Dial: 304.340.3829
E-Mail: tcox@spilmanlaw.com

July 25, 2005

BY HAND-DELIVERY
Victor A. Mullins
Associate Counsel
Legal Division
West Virginia Insurance Commission
1124 Smith Street
Charleston, West Virginia 25301

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

RE: **Comments to Proposed Administrative Rules Title 114, Series 14**

Dear Mr. Mullins:

With over 400 leading property and casualty insurer members, many of whom write business in West Virginia, throughout the United States and the World, the American Insurance Association (AIA) have a substantial amount of experience with insurance trade practice regulation and third party bad faith issues. AIA appreciates the leadership of Commissioner Cline and the Governor in reforming third party bad faith in West Virginia and, as recent rate reductions demonstrate, that hard fought effort is already producing measurable results for all West Virginians.

With the legislation now passed, AIA recognizes that the hard task of conforming regulations to that reform must proceed. We look forward to a constructive dialogue with all stakeholders as this process unfolds and appreciate this opportunity to comment on the proposed changes to 114 CSR 14. We believe these comments will underscore several needed changes in the proposal and welcome your questions as this effort moves forward.

1.1(c) We believe that the NAIC Model should be followed, and the rule should also exempt medical malpractice, boiler & machinery and bonds.

2.14 Definition of "Egregious Act." We are concerned with "clearly irresponsible" conduct constituting an egregious act. Irresponsibility could be something as simple as losing a phone number and not returning a phone call. This is a very low standard and needs to be strengthened in some material way or it will essentially overwhelm "egregious" as the standard. Furthermore, the modifier "simple" should be removed from "simple negligence" because as written this means that standard "negligence" alone can constitute egregious conduct. That can not be the intent.

4.5 The proposed language is novel, unclear and overly broad. As written, if a carrier does not pay a person all he asks for that will be misrepresenting a policy provision. We are aware of nothing similar and that is with good reason, as it does not allow insurers to test the accuracy of claims. Moreover, the language "which should be included" is subject to differing and varied

interpretations. If what is meant by this is "what has been agreed to," then that language should be used. As written, this will result in a lot of claims of unfair practices that are without merit.

5.1 Changing the time frame from 15 to 10 days seems unnecessary and will complicate insurer compliance efforts. We are unsure why written notice from an unauthorized agent is necessary to avoid the insurer being held responsible. As a practical matter this is an unauthorized agent, why would she or how could the insurer force her to provide the notice when they are "unauthorized." Moreover, why must it be in writing? It should be in the same means that notice is given to the agent. That could be in person, by phone, facsimile, Internet, e-mail etc.

5.2 Changing the time frame from 15 to 10 days again seems unnecessary and will complicate insurer compliance efforts. This is particularly true when the compliance burden is being expanded in the provision. This is also true about the change in the start of response time from receipt of the inquiry to date of correspondence. The existing days and trigger should remain. The requirement that insurers address "all issues raised by the complainant" will have broad reaching consequences. Insurers often get remarkably broad ranging issues from claimants and we expect the same is true of the Commission. Thus, they often have little or no connection to the claim. Consequently, we ask that "all issues raised by the complainant or the Commission" be modified by adding at the end "material to the claim at issue." Finally, there should be some exception for privileged materials that the Commission would not ordinarily have access to, such as attorney-client communications, etc.

6.2 Changing the time frame from 15 to 10 days again seems unnecessary and will complicate insurer compliance efforts.

6.4 The proposed language provides that "Offers must be calculated in third party claims in the same manner as would be used if the claim were made under a first party coverage by one of its insureds." This is simply not possible because first party and third party losses are governed but entirely different coverages and laws. For example, third party claims do not have deductibles or limitations on specific items of loss. While, on the other hand, first party claims are not reduced because of the person's fault. In addition, the whole effort to reform third party bad faith was an acknowledgment that the law in West Virginia had gone to far in making third parties alike contracting parties, which they are not. Thus, this language is fundamentally flawed and should not be added.

6.5 This entire section establishes the commissioner as the final claims adjuster. It is entirely new and unprecedented. Moreover, the proposed factors are limited and give insurers virtually no means to present their own positive evidence of claim value, but rather require them to react to claimant and/or the commissioner's evidence of value or present evidence only on how they considered claimant value evidence. This is inherently unfair and will preclude a lot of evidence of value that is legitimate and probative.

6.6 Having to deliver all coverage denials in writing is both unnecessary and a burden, since many are for the most obvious reason, such as the date of loss predating the policy or the claim being presented to the wrong insurer, and the claims themselves are being delivered by means other than in writing. If, for instance an insurer redirects the claimant to the correct insurer for his claim when they are on the phone, that act would require a coverage denial letter. This can not be the intent and this provision should be modified to prevent such results. In addition, it should allow for denials to be communicated on the same basis that they are presented including telephone, mail, facsimile, internet, e-mail, etc.

6.7 This section requires carriers to provide all insureds and claimants with status reports every 30 days until they pay or deny the loss. The only exception is when the carrier has grounds to believe the claimant "fraudulently caused the loss." It is important to note that this approach will, of course, alert people under investigation for fraud since that is the only exception. Consequently, the whole approach should be reconsidered and discarded.

If not rejected several important points must be considered. For example, the great bulk of claims fraud is associated with legitimate accidents that then are fraudulently "enhanced" through unnecessary treatments, etc. Consequently, removing the "or contributed" language makes little sense. In fact, this exception needs to be expanded to fraud that will be committed, such as the claims that are "enhanced." In this way, the end of the sentence should read "that such claimant has fraudulently caused or contributed to the loss or the claimant may have committed or be about to commit insurance fraud."

There should also be an exception to the notice timing for any claim where the claimant is represented by an attorney. Plaintiff attorneys are notorious for dragging out a claim, and ignoring adjusters' requests for information for months on end. To require a carrier to send the claimant a status report every 30 days on represented cases is wrong. The claimant can find out the status, as should anyhow, from her counsel.

For all other status reports, we believe they should be on 45 day intervals as that is the NAIC model time frame. 30 days is often too brief a time frame on larger claims.

6.10 This provides that carriers have to inform third party claimants, in writing whenever they disclaim "liability" because there was no policy in force OR the insured has violated a policy provision. First, this should be "coverage" rather than liability. Second, the later requirement, violation of a policy provision, is a serious breach of the insured's privacy rights. The claimant is not a party to the policy contract, which is a private contract. The claimant should no be privy to matters between the contracting parties, particularly sensitive items such as the insured conduct.

6.12 Subpart "a" holds carriers "responsible for the accuracy of data used to establish the value of insurance claims." The language is overly broad. Carriers can only be held responsible for data that they themselves develop or that their contractors develop. They cannot be held responsible

for data supplied by the insured, the claimant, or their representatives. This needs to be modified to reflect this important distinction.

6.17 While we understand the concern of avoiding unnecessary claims denials, this prohibition is simply too broad. The vast majority of claims that are denied are done so properly. When claims are properly denied, that process correctly affects the insurer's performance and, consequently, its stakeholders and employees. Thus, in some way, all denials compensate stakeholders, including policyholders through premiums, and employees, through salaries, company wide bonuses and/or company profit sharing. Thus, this overly broad prohibition interferes with insurers' rights to contract both with insureds and insurer employees and the benefits of proper claims management that insurer stakeholders expect. This provision must be modified to reflect an important distinction between inappropriate denials and proper ones.

6.18 This section provides that "No insurer may advise a claimant not to obtain the services of an attorney or public adjuster or suggest the claimant will receive less money if an attorney or public adjuster is used to pursue or advise on the merits of a claim." First, as a practical matter, there is ample objective evidence that claimants will receive less money in these situations and telling people the truth benefits them. Second, this prohibition violates free speech. The state can not tell insurers they are not allowed to voice their opinion on this subject. This is no different than the state seeking to tell attorneys they can not advise claimants that the attorney can help them in their dispute. Neither is constitutionally defensible. This provision must be deleted as it is subject to First Amendment challenge.

6.20 We are not clear why this section was added and it will have definite implications for property claims investigation. Not allowing insurers to require the production of tax or income information except under the narrowest of circumstances will create a serious problem in fraud investigations. In both personal and commercial property losses, if the insurer suspects fraud, obtaining the insured's financial picture is critical. Moreover, if only a fraud exception is added here, that will serve to alert the subject of any such investigation, which could have dire consequences for the outcome. Consequently, this proposed addition should be removed in its entirety.

8.2 This is an unusual provision that seemingly returns insurers to the business practices that arose under third party bad faith. In a nutshell, this requires that when a third party claimant reports a loss (rather than the insured), and the insurer believes it is not responsible, it has to deny the claim to ***the claimant*** in writing within 10 days. First, this establishes special rules that apply when a claimant reports a loss as opposed to when the insured reports it. Second, what is meant by "not liable?" Are these "no coverage" situations or "no liability" situations because the third party is at fault?

It seems the intent is to determine whether there was insurance in force. In that case, the provision should simply require the insurer to advise the claimant on whether there was insurance in force at the time of accident within a reasonable time frame. The proposal also requires

insurers to send a claimant a written acknowledgment of the claim. That ignores that business is conduct in all manner of ways from phones to facsimiles to e-mail. Insurers should be allowed to communicate in the same manner as the inquiry is received.

Perhaps of greater concerns is that the communication must tell the claimant several things, including that the policy covers "loss of use of damaged property and any other out of pocket expenses reasonably attributable to the accident." We seriously doubt that state tort law requires payment of "any other out of pocket expenses...." Rather, they must be reasonable AND necessary and casually connected to the accident; we are unsure where the "reasonably attributable" standard comes from. Moreover, the vast majority of people receiving such a letter will not understand the difference between coverage for something and liability for the same element of damage. In many liability claims, the claimant is at least partially at fault. Consequently, this standard may encourage claimants to believe they have a greater entitlement than actually provided under West Virginia Law. That will, of course, generate unnecessary disputes.

Given its broad reach and inherent problems, we believe this provision should be stricken in its entirety. Failing that, there should be specific changes to address the foregoing concerns and an exception for cases where the claimant is represented by an attorney as it is their attorney's obligation to apprise their clients of their rights and obligations and insurers could be excuse of interfering with attorney-client relationships.

8.3 The 7 day time frame for notifying the insured of its "failure to cooperate" is very short and will create problems between the insurer and insured. For example, an insured could be on vacation, or worse, in the hospital from the accident at issue and unreachable. This provision could result in coverage disputes where none exist. We believe that the standard should be a "reasonable time frame." This will allow necessary flexibility to avoid impairing the insurer-insured relationship.

Finally, by regulation the Commission proposes to amend West Virginia cooperation coverage law with the provision: "No insurer may deny or fail to adjust an otherwise valid third party claim because of the failure of the insured to cooperate unless the insurer can prove the ***lack of cooperation is material, substantial and to the prejudice of the insurer***."

This, however, is not the standard for a cooperation denial in West Virginia. As the West Virginia Supreme Court said in *Bowyer v. Thomas*, 188 W.Va. 297, 301-02, 423 S.E.2d 906, 910-11 (1992) *citing Marcum v. State Automobile Mut. Ins. Co.*, 134 W. Va. 144, 59 S.E.2d 433 (1950):

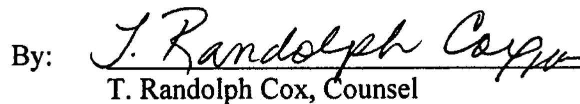
> "before an insurance policy will be voided because of the insured's failure to cooperate, such ***failure must be substantial and of such nature as to prejudice the insurer's rights***.

(footnotes omitted). Thus, there is no "material" component. This stands to reason because substantial would, by its nature, include only material failures. The standard should be written to follow West Virginia case law.

Thank you for considering these comments. We appreciate your difficult task of providing useful guidance that conforms to the recent legislation and West Virginia case law. We believe these comments will aid in this process. If you have any questions please do not hesitate to contact us.

Respectfully submitted,

American Insurance Association

By: 
T. Randolph Cox, Counsel

TRC/lb; 367017
cc: The Honorable Jane L. Cline, Insurance Commissioner
Mary Jane Pickens, General Counsel

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #12

FARMERS & MECHANICS MUTUAL INSURANCE CO. OF WEST VIRGINIA

Insuring West Virginians Since 1877.

July 21, 2005

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

Victor Mullins, Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
Charleston, West Virginia 25305-0540

Re: Proposed Rule Amendment to 114CSR14

Dear Mr. Mullins:

This is to provide you with our comments concerning the proposed Rule Amendment to 114CSR14. This letter is intended to be a confidential communication not subject to disclosure under the Freedom of Information Act.

§114-14-2.14 "Egregious Act" is defined using language other than its plain, ordinary meaning. An egregious act is conspicuously and outrageously bad or reprehensible. A clearly irresponsible act is not necessarily conspicuously bad or reprehensible. Moreover, the inclusion of the term "simple negligence" in defining what is not an egregious act implies that any other standard of negligence is an egregious act.

§114-14-5.1 Reducing the time requirement for acknowledgment of notices of claims from fifteen (15) to ten (10) working days is unduly burdensome.

§114-14-5.2 Reducing the time requirement for responding to an inquiry from the Insurance Commissioner from fifteen (15) working days of receipt of such inquiry to ten (10) working days of the date appearing on the inquiry is unduly burdensome. Moreover, the requirement to respond to an inquiry based on the date it is made, and not the date it is received, is fundamentally unfair and contrary to due process.

§114-14-5.3 Reducing the requirement to reply to pertinent communications from a claimant from fifteen (15) to ten (10) working days is unduly burdensome. Further, this section does not set forth whether the time requirement for the response is based on the date it is made or the date it is received.

§114-14-5.4 The proposed reduction of time for compliance from fifteen (15) to ten (10) working days is unduly burdensome.

PO BOX 1917, MARTINSBURG, WV

§114-14-6.2 Reducing the time requirement for commencing an investigation of a claim from fifteen (15) to ten (10) working days in is unduly burdensome. The reduction of time for providing notification of all items, statements and forms from fifteen (15) to ten (10) working days of receiving notice of the claim is also unduly burdensome. Claims handling is often a fluid process which changes depending on investigative findings. The determination of what items, statements and forms may be required may be controlled by the investigative findings.

§114-14-6.3 The time requirement proposed for denying a claim in writing or making a written offer is unduly burdensome.

§114-14-6.4 The proposal to advise a claimant when a claim presented is greater than policy limits is potentially a violation of the Graham-Leach-Bliley Act. This proposal would require an insurer to provide a third party with private financial information of its policyholder without the policyholder's authorization to do so.

§114-14-6.5 The proposals in this section are fundamentally unfair and unduly burdensome. Further, this proposal would require the waiver of attorney-client privilege in order to present evidence of compliance.

§114-14-6.7 The proposal to reduce the time requirement for notifying a claimant of a delay in investigating a claim from fifteen (15) to ten (10) working days is unduly burdensome. The proposal to change this delay notification from first party claims to all claims is also unduly burdensome.

§114-14-6.10 The vagueness of this proposed rule would require insurers to notify third party claimants of the specific reasons why coverage is disclaimed. Additionally, the word "liability" contained in this proposal should be changed to "coverage".

§114-14-6.12 This proposal would significantly curtail an insurer's ability to establish the value of a claim and would lead to additional delays in settling claims where coverage, damages &/or negligence are reasonably clear.

§114-14-6.17 This proposal would make it a violation for an insurer to offer compensation to its employees, agents or contractors based on savings to the insurer as a result of denying the payment of claims. The word "solely" should be inserted after the word "based". Additionally, the word "improperly" should be inserted prior to the word "denying".

§114-14-6.20 This proposal would eliminate an insurer's ability to obtain evidence of a claimant's income. The income of a claimant is pertinent in determining the true amount of property loss and failure to use this to support a claim would increase the potential for fraud. Additionally, the income of a claimant is pertinent in evaluating a claim for future wage loss.

§114-14-6.22 This proposal would require an insurer to provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation. This would require such notice in every first party claim. This is unduly burdensome.

§114-14-6.24 This proposal would require certain information for all claim denial notices. The required information proposed is unduly burdensome.

§114-14-8.1 The terminology of "affording coverage" to third parties should be stricken. Coverage is not afforded to third parties.

§114-14-8.2 The standards proposed are unduly burdensome. The proposed standard is that an insurer shall deny a claim within ten (10) working days of its notice, based on a good faith belief. This is not an appropriate standard for denying a claim. A denial should only be made after appropriate investigation.

§114-14-9.1 It is unduly burdensome to have to advise the commissioner of all claim settlements in matters in which a complaint has been made.

§114-14-9.2 This proposal is fundamentally unfair in that it imposes a duty on only one party to negotiate in good faith.

§114-14-9.3b This proposal creates a new legal standard of an "egregious act" not contemplated by the statute. This proposal would allow for restitution regardless of whether the act occurred within a general business practice. The Unfair Trade Practices Act only provides for investigation and hearing to determine if the person has committed an unfair claims settlement practice with such frequency as to constitute a general business practice. The Unfair Trade Practices Act allows administrative action for findings of an unfair claim settlement practice which is a general business practice or an intentional act. The Unfair Trade Practices Act does not allow for administration action for "egregious acts".

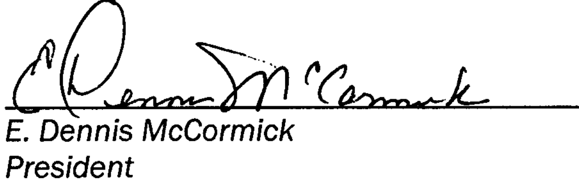
§114-14-10 The training and certification requirements are unduly burdensome.

Victor Mullins, Associate Counsel
re: proposed Rule Amendment to 114CSR14
July 21, 2005
page four

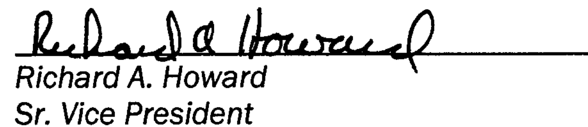
Lastly, we object to any rule change which is not necessitated by the enactment of Senate Bill 418 during the 2005 regular session. It is clear that the intent of the Legislature, in authorizing the Insurance Commissioner to promulgate an emergency rule, was to allow for amendments so that the administrative process would conform with the legislation.

Thank you for your consideration.

Sincerely,



E. Dennis McCormick
President



Richard A. Howard
Sr. Vice President

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #13

Victor Mullins

From: cemartin [cemartin@martinandseibert.com]
Sent: Monday, July 25, 2005 3:36 PM
To: Victor Mullins
Cc: markcluse@westfieldgrp.com
Subject: Insurance Commissioner's proposed changes to 114 CSR Series 14
Attachments: 0725144032.pdf

Mr. Mullins:

Please find attached to this email a letter addressed to you which contains the comments of my client, Westfield Insurance Company, to the Insurance Commissioner's proposed changes to 114 CSR Series 14 concerning the Unfair Trade Practices Rules. The letter is also being faxed and the hard copy is being overnighted.

If you have any questions, please do not hesitate to contact me.

CEM

Clarence E. Martin, III, Esq.
Martin & Seibert, L.C.
1453 Winchester Avenue
P.O. Box 1286
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==+++====
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July 25, 2005

West Virginia Insurance Commissioner
Attn.: Victor A. Mullins, Esq.
1124 Smith Street
Charleston, WV 25301

Via facsimile and U.S. Mail

Re: ***Comments of Westfield Insurance Company to proposed changes to Insurance Commissioner Rules***

Dear Mullins:

Please accept this letter as the comments of my client, Westfield Insurance Company, to the Insurance Commissioner's proposed changes to 114 CSR Series 14 concerning the Unfair Trade Practices Rules. According to my conversation with the West Virginia Insurance Commissioner's Office, the proposals are open for public comment through 5:00 p.m. July 25, 2005.

Overall, we find the proposed rule changes to be too onerous for a property/casualty insurer adjusting personal injury and property damage claims in West Virginia and may lead to additional litigation by first and third party claimants. In all, the proposed changes include three new sections, specifically §14-8 entitled "Standards for Prompt, Fair and Equitable Settlement of Third-Party Property Damage Claims Arising Under Motor Vehicle Liability Insurance Contracts," §14-9 entitled "Third Party Administrative Complaints" and §14-10 entitled "Training and Certification." [1] In addition, there is an overhaul of §14-4 previously entitled "Unfair Or Deceptive Acts Or Practices" now entitled "Representation of Policy Provisions and Benefits." Finally, there are several name changes indicating, for example, that these are rules rather than regulations and identifying the Insurance Commission as a Commission rather than a Department. These proposed changes, just as with existing rules, apply to all lines of insurance except workers' compensation. Interestingly, the proposed change also includes in the scope of the rule a new statement ("e") indicating that "[n]othing in this rule creates or recognizes, either explicitly or impliedly,

[1] These section numbers correlate with the proposed changes and in many instances are inserted between existing sections thus causing a renumbering of the Series. All section numbers cited herein track the proposed rules rather than the existing rules.

any new or different cause of action not otherwise recognized by law." Presumably, this is in reference to the recent amendment to W.Va. Code §33-11-4 which, *inter alia,* abolished a private cause of action for third party "bad faith" suits.

Below is our analysis of each proposed change.

Definitions

The proposed changes includes additional definitions for the West Virginia Insurance Commissioner, §2.12; "licensees" which are defined as "any person that holds a license or Certificate of Authority from the commissioner, or any other entity for whom the commissioner's consent is required before transacting business in the State of West Virginia or with residents of West Virginia," §2.13; and "Egregious Act," §2.14.

It is the definition of "Egregious Act" which is somewhat troubling. An "egregious act" is defined in §2.14 as "conduct that is clearly irresponsible, fraudulent, or malicious and reckless, whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice. An act, or failure to act, that is due to simple negligence, lack of judgment, incompetence, or bureaucratic confusion, is not an egregious act."

First, the definition seems internally inconsistent in that it adopts the standard set forth in *McCormick v Allstate*, 202 W.Va. 535, 505 S.E.2d 454 (1998), as something that does not constitute an act of "actual malice," yet finds an egregious act to be one that is "irresponsible." "Irresponsible" is analogous to negligence yet "simple negligence" is not an "egregious act" as per the definition.

Furthermore, neither the definitions nor any other section of the rule indicates who will make such findings, at what stage said findings will be made nor the burden of proof any party must bear in order for a finding of an "egregious act." Given the adoption of the legal term of "negligence," we presume the burden of proof will be by a preponderance of the evidence, yet given that the definition encompasses fraudulent acts, we would argue that such proof must be by clear and convincing evidence.

File and Record Documentation

The only substantive proposed change to §3.1 isan additional requirement that all communications, whether written or oral, be dated by the insurer and that insurers must either notate in the file or retain a copy of all forms mailed to claimants.

With respect to dating entries, given that most carriers are computerized at this time, this should not be an undue burden nor a change to everyday claim handling procedures. Moreover, notating that a form has been mailed to claimants - from the claim department - should not be a major change. Some carriers, however, do not have their claim handling systems configured in such a way as to maintain copies of forms which may require a

system change. The only remaining issue, however, is that the rule is unclear as to which forms it is referring. Claim forms, for example, should not be problematic. However, to the extent that "all forms" may include underwriting forms, this may be an issue. The most obvious example is a selection/rejection form for optional UM and UIM coverage limits. Said forms are generally maintained by underwriting departments, but may become relevant to the handling of a claim. At a minimum, clarification of the rule should be explored with the Commission. This arguably applies to all incoming mail as well and may thus require a change to claim handling procedures if a carrier is not date stamping incoming mail.

Representation of Policy Provisions and Benefits

Section 14-4 has been renamed and additional subsections have been added. Section 4.1 now imposes positive duties on an insurer with respect to first party claimants.[2] However, the proposed rule also indicates that this positive duty also runs to beneficiaries. "Beneficiary" is not defined in the proposed rule. The West Virginia Supreme Court of Appeals held in *Bowyer by Bowyer v Thomas*, 188 W.Va. 297, 423 S.E.2d 906 (1992), that automobile liability insurance is "chiefly designed for the benefit of third parties injured by a negligent driver, and the goal of liability insurance is to extend the maximum protection possible consonant with fairness to the insurer." Given this explanation, it is reasonable to question whether inclusion of the undefined term "beneficiary" in this proposed section is intended to extend the application of this section to third party claimants.

The proposed change indicates that insurers shall disclose to a first party claimant "or beneficiary," all benefits, coverages, time limits or other provisions of any insurance policy that may apply to the claim. When "additional benefits" might reasonably be payable upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and "cooperate with and assist the insured in determining the extent of the insurer's additional liability."

Certain portions of this proposed section seem limited to first party claims and if it is the intent of the Commission to so limit this section to first party claims, we recommend that the introductory statement delete "or beneficiary" or be amended to more fully define the scope of this section's application. Furthermore, in situations where certain coverages are not triggered by the facts of the loss, most carriers are not disclosing said coverages to claimants which may require a change to claim handling procedures. This is also problematic in instances where an insured may be presenting a UM or UIM claim and a potential *Bias* claim may exist. At the time of the initial contact with the insured, the claim representative may only have available to him or her the declarations sheet or pull down policy data and may not have access to selection/rejection forms or other similar information that might demonstrate that UM or UIM coverage is either available or may be

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[2]The definition of a "first party claimant" remains the same. "First Party Claimant" or "Insured" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract. §2.3

available in a higher amount. Imposition of this new requirement would therefore be impossible for claim representatives to follow without making such underwriting documentation available to the claims department without the need for a special request. In addition, should this section apply to third party claims, it requires the disclosure of an insured's policy limits which is obviously problematic. Although the West Virginia Supreme Court has overruled an insurance carrier's arguments that revealing such nonpublic personal financial information constitutes a violation of the Gramm-Leach-Bliley Act, we nonetheless believe that an insured must first consent to the release of policy limits information in the claim process before suit is filed and the information is subject to discovery. If this section applies to third party claims and in intended to require the disclosure of an insured's policy limits, we would recommend that the section be amended to specifically identify such so as to protect against future first party claims when such information is revealed.

It is also unclear as to the intent of the Commission in the sentence that imposes additional duties upon an insurer when "additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim." Moreover, "immediately" is not defined as to any specific time frame. Given the reduction of time for other file handling activities from 15 to 10 working days which will be discussed *infra,* we presume such time frame would apply in this situation as well.

This proposed change to §4.1 may require amendment to claim manuals or best practices guides and will require additional training of claims personnel, particularly in centralized offices or call centers which often have initial contact with insureds with respect to disclosure requirements.

The Commission is also proposing the addition of two subsections to this renamed section of the rule, the first being §4.4 entitled "Time limit for notification of claim." It permits a carrier to specify in its policy a time frame for a first party claimant to give notification of a claim or proof of claim. If a carrier wishes to do so, amendment to policy forms would be in order, subject to approval of the Commission's Rates and Forms Division. Otherwise, an insurer may not impose a time limit for the notification of a claim or proof of claim. This seems obviously inconsistent with applicable statutes of limitations and other sections to be discussed herein about the time in which an insured must notify an insurer of a loss and cooperate when third party claims are asserted. This is also contrary to W. Va. Code §33-6-31(e)(ii) concerning John Doe UM claim notification requirements which requires a claimant to notify an insurance company within 60 days of the accident.

The Commission is also proposing §4.5 entitled "When settlement payment treated as communication." This section, although oddly written, essentially imposes upon an insurer the duty to explain settlement offers. Failure to explain all amounts "which should be included according to the claim filed by the claimant and investigated by the insurer" shall be deemed a communication that misrepresents a pertinent policy provision.

The West Virginia Supreme Court held in *Miller v Fluharty*, 201 W.Va. 310, 500 S.E.2d 685 (1997), that an insurer must explain the basis of all settlement offers made in first party claims if rejecting a demand within policy limits. Such duty has never been

extended beyond first party claims and this proposed subsection would expand such duty. Moreover, it is less than clear what the Commission intends an insurer to explain when it imposes a duty to explain all amounts "which should be included according to the claim filed by the claimant and investigated by the insurer." For example, if a property damage settlement is made while a personal injury or medical payments claim is pending, arguably, such additional claims must be addressed within the property damage settlement. Given the specialization of claims representatives by types of coverage, such would be impossible.

This obviously will require 1) clarification and 2) additional training of claims personnel when communicating settlement offers. In order to protect the integrity of the claim handling process, this should also necessitate a change in procedures to make all settlement offers in writing.

Standards for the Acknowledgment of Pertinent Communications

The most pronounced change in the proposed rules falls within this section, that being the reduction of time for claims to be handled from fifteen (15) working days to ten (10) working days. This applies to acknowledgment of notices of claims, §5.1;answering inquiries of the Insurance Commission, §5.2; replies to pertinent communications, §5.3; and providing assistance to first party claimants, §5.4.[4] This reduction of time also applies to the time in which insurers must commence an investigation of any claim, §6.2; the time to deny a claim or make an offer, §6.2; subsequent notifications of necessary delays in investigating claims, §6.7; notice to third party claimants of denials of claims, §8.1; and requests to third party claimants of additional information necessary to process a claim, §8.2b. Each are discussed more fully herein

We believe that the overall reduction of time for claim handling activities from 15 working days to 10 working days is adverse to the interests of the insurance industry and will lead to an increased number of timeliness violations. It is particularly troubling to the extent it applies to "pertinent communications" since plaintiff's counsel could easily barrage a claim representative with "pertinent communications" many of which could not be responded to within such a short time. In addition, day-to-day practice would indicate that certain information vital to an investigation such as the request for a police report or medical records can not be obtained within 10 working days and will now impose additional requirements on a claim representative to explain why more than 10 working days is required to complete certain tasks and respond to "pertinent" communications or to make settlement offers.

With respect to acknowledgment of notices of claims, §5.1, the Commission has also proposed an additional provision that permits notification of claims to be made to

[3]This proposed amendment imposes the restricted time limitation unless full payment is made within such period of time.

[4]Although not specifically addressed, we presume for purposes of this analysis that the reduced time frame of 10 business days will apply to the newly imposed disclosure requirements of §4.1.

agents which will constitute notice to the insurer. The new provision states that "If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent promptly notifies the claimant in writing that the agent is not authorized to receive notices of claims."

This is also problematic in several ways. First, "agent" is broadly defined in the rule as "any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim." §2.1 (emphasis added). It does not appear from this definition that "agent" is intended to cover selling agents. Yet, the proposed change to §5.1 would lead one to conclude that selling agents could receive notices of claims. [5] Second, assuming selling agents are to be receiving initial notices of claims, extensive training will be required in order to assure that such notices are timely responded to and forwarded to claims, particularly given the reduction of time to respond from 15 working days to 10 working days. Third, the term "promptly" is not defined to cover instances in which selling or other "agents" are not authorized to receive notices of claims. (This is the same for the proposed amendment to §6.2). In the event a carrier chooses not to authorize selling agents to receive notices of claims, a form notice should be created and a process instituted whereby said form is transmitted to the claim department to comply with proposed §3.1. Fourth, this section does not address the situation of carriers utilizing independent selling agents and will require a carrier-specific business decision as to whether to authorize said independent selling agents to receive notices of claims. This section also does not address the needs of insurers who engage in direct marketing and sales via the Internet. Finally, the proposed new language is difficult to follow and we would suggest that the language be changed to that stated in §6.2

Standards for Prompt Investigation and Fair And Equitable Settlements Applicable To All Insurers

This section contains several changes and additions. First, the Commission is proposing a new §6.1 entitled "Investigation of claims" which again imposes a positive duty on insurers to "promptly" conduct and "diligently pursue" a "thorough, fair and objective investigation" and not to "unreasonably" delay resolution by "persisting" in seeking information "not reasonably required for or material to the resolution" of a claim dispute. While this is a good statement of public policy and one would hope all carriers would conduct such investigations in pursuit of a resolution of a claim, it is problematic in that the terms are vague and ambiguous, subject to myriad interpretations and apparently left to the discretion of the Commissioner and/or juries who may consider first party "bad faith" claims without regard to evidentiary standards or further definition.

Section 6.2 only proposes to reduce the time frame for investigations from 15 to 10 working days and changes language concerning notices of claims to agents as discussed

[5] Some companies, such as State Farm Mutual Automobile Insurance Company, encourage insureds to make initial notices of claims through their selling agents.

above. However, the Commission has made no changes to what we perceive to be an internal inconsistency in the language of the existing rule. The first sentence of this section refers to "any claim filed by a claimant" which would therefore include third party claims. However, the next sentence, requiring notification of items, statements and forms, is limited by its language to first party claimants. We believe this is internally inconsistent and this would be an appropriate time to recommend a clarification of existing language as well.

The Commission also proposes to add a requirement in §6.3 that within 10 working days of the completion of its investigation, that the insurer either deny the claim in writing, or make a written offer, subject to policy limits. But for the reduced time limitations, we have no criticism of this proposed addition. This may require some change to claim handling procedures to certain companies.

The Commission has also proposed a change to §6.4 governing settlement offers. The existing language of the rule states, in pertinent part, "In any case where there is no dispute as to coverage or liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable..." The Commission now proposes to change the word "or" to "and."

More troubling than this change, however, is the proposed addition to §6.4 which states: "If the claim presented is greater than policy limits, then the claimant must be so advised. Offers must be calculated in third party claims in the same manner as would be used if the claim were made under a first party coverage by one of its insureds." This again calls for the disclosure of an insured's liability limits to a third party which is a violation an insurer's duty to its insured as discussed, *infra.*

This proposed addition is silent as to how the claimant must be advised if the carrier evaluates the claim in excess of policy limits; however, given the overall preference for written communication, throughout the rule, we presume this too is to be in writing. The proposed addition is also silent as to what information must be presented to a claimant about the evaluation process utilized by the insurance carrier and the valuation placed on the claim by the carrier. Moreover, the requirement that offers in third party claims must be calculated in the same manner as first party claims is unclear and will require clarification before we can comment further on this provision.

Especially troubling about this proposed addition is the imposition of a requirement upon a carrier to advise a claimant - first or third party - as to its evaluation when the value exceeds policy limits. This overlooks the recurrent situation of a claim in which the same carrier has both liability and underinsured exposure - sometimes referred to as "cross files" or "double width" files. It is prejudicial to the interests of the carriers and potentially the tortfeasor in such situations for a claim representative handling the liability claim to reveal the evaluation which might expose the excess carrier and potential personal assets of the tortfeasor. Moreover, to the extent that the West Virginia Supreme Court has imposed a duty on liability carriers to act in good faith toward excess carriers, revealing an evaluation and presumably the value placed upon a claim simply because it exceeds liability limits could violate the dictates of *State ex rel. Allstate v Karl,* 190 W.Va. 176, 437 S.E.2d 749 (1993), *cert. denied*, 570 U.S. 1194 (1994). This new requirement overlooks the

practicalities of day-to-day claim handling as well. Often times a claim will clearly exceed policy limits based upon limited investigation, i.e., a clear liability death claim with a minimum limit liability policy. In such instances, very little investigation and little to no evaluation of damages may be performed by the liability carrier in order to determine that the claim exceeds available policy limits. Rather than just offering the limits, this new section seems to suggest that a carrier must nonetheless complete a liability and damages analysis and place a value on the claim so as to provide it to the third party claimant because the value of the claim is greater than policy limits. This, therefore, would slow rather than speed the claim handling process in contravention of the stated purpose and the presumed intent of the rules. Furthermore, the proposed amendment is silent as to the admissibility, if any, of the disclosure by the carrier of its evaluation when the value exceeds available policy limits. It is foreseeable that in the context of a UIM claim that the liability carrier would now be required to disclose its evaluation of the claim which the claimant would then use in pursuit of a UIM claim and might attempt to introduce the liability carrier's evaluation as "proof" as to the value of the claim.

If passed, this section would require extensive re-training of claim representatives and potentially the creation of additional forms for the disclosure of an evaluation when a claim exceeds available policy limits.

The Commission has further attempted to change the manner in which claims are adjusted by the proposed addition of §6.5 entitled "Unreasonably low offers." Which, it is the goal of carriers not to make unreasonably low offers, attempts to regulate against such activity is problematic, particularly as stated in the proposed addition. The Commission is interjecting itself into the adjustment process by this proposed addition and also seeks to invade the attorney-client privilege. Due to the damaging nature of this proposed addition, it is cited in its entirety for your review and consideration as well:

> 6.5 Unreasonably low offers. – No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:
>
> a. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
>
> b. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;
>
> c. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
>
> d. The extent to which the insurer considered the advice of its counsel regarding the likelihood of recovery in excess of policy limits;
>
> e. The procedures used by the insurer in determining the dollar amount of property damage;
>
> f. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other

final determination of the matter; and

g. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

This section is obviously troubling in many regards. First, it is unclear when the Commissioner may become involved in reviewing such issues and again contains vague and ambiguous terms such as "unreasonably low," "credible evidence" and apparently imposes a new standard that being what a "reasonable person would have offered in settlement of the claim taking into consideration the relevant facts and circumstances at the time the offer was made."

Moreover, this new section appears in direct contravention to the recent amendment to the Unfair Trade Practices Act which states: "A good faith disagreement over the value of an action or claim or the liability of any party to any action or claim is not an unfair claims settlement practice." W. Va. Code §33-11-4a(g).

To the extent the determination of what constitutes an "unreasonably low offer" requires consideration of advice of an insurance carrier's counsel, (subsection d) this is a blatant violation of the attorney-client privilege. As written, this section automatically waives the privilege and permits inspection of advice of counsel. In that it is vaguely written, we presume this would apply only to counsel hired to defend or provide advice to the insurance carrier rather than defense counsel hired to defend the insured, but would strongly suggest that 1) this provision be eliminated or 2) be clarified as to which counsel this section applies to. Clearly, an insured has the right to counsel and communications, even as between the carrier and the insured's counsel, are protected by the *quasi* attorney-client privilege. *State ex rel. Allstate v Gaughan,* 203 W.Va. 358, 508 S.E.2d 75 (1998). The traditional attorney client privilege applies to insurance carriers who retain counsel directly, including in the defense of UIM or UM claims adverse to the insured, *State ex rel. Allstate v Madden,* 215 W.Va. 705, 601 S.E.2d 25 (2004). To permit the Commissioner, or any other individual the unfettered right to review advice of counsel when the carrier has not made a case-by-case decision as to whether to waive the privilege is tantamount to a complete evisceration of the privilege and should be vigorously opposed during this comment period.

Moreover, the likelihood of an excess verdict is not the proper standard when considering a first party claim. If a carrier defends a claim such as a UIM claim and a verdict is returned in excess of policy limits, the burden then shifts to the carrier in a subsequent "bad faith" claim to demonstrate - by clear and convincing evidence - that it acted as a reasonably prudent insurer would under the same or similar circumstances. *Marshall v Saseen,* 192 W.Va. 94, 450 S.E.2d 791 (1994).

It is further unclear why the commissioner, in the context of a personal injury claim, would specifically consider procedures used by an insurer in determining the dollar amount of property damage, (subsection e). We believe this is incorrectly placed in this subsection and has no bearing on whether an insurer made an "unreasonably low offer" of a personal injury claim. To the extent the Commissioner chooses to monitor or regulate property damage claims by reviewing procedures insurers utilize in determining the dollar amount of property damage claims, this subsection should be placed in a later paragraph of the rule which specifically governs property damage.

Consistent with all other changes to the rule about statements being made in writing, the Commission is striking any other method of denying a claim in §6.6. We do not find this to be problematic and in fact promotes good claim handling procedure.

As with other time requirements, the Commissioner is proposing changing the time in which to provide notice of delays in investigating claims in §6.7. The existing language of the rule limited this subsection, previously §6.5, to first party claims. Such limitation is now proposed to be stricken. As to all claims, the Commission is attempting to require insurers to notify all claimants within 10 rather than 15 working days if more time is necessary to investigate a claim. As proposed, a carrier would be entitled to 30 calendar days from the date notice of a claim is received to determine if a claim should be accepted or denied. If additional investigation is necessary, a carrier would now be required to notify a claimant of such in writing within 10 working days after the 30 day period expires and every 30 calendar days thereafter until the investigation is complete. The application of this section is proposed to be restricted so that carriers are relieved of this obligation when investigating claimants the carrier suspects fraudulently caused a loss. The section presently exempts a carrier from this notification requirement not only for those suspected of causing a loss but also those who contributed to the loss.

Conversely, however, the application of the section is proposed to be expanded in that it is presently confined to suspected losses "caused by arson." Arson is proposed to be excluded and thus this section would now arguably apply to all losses in which fraud is suspected. In that regard, the Commission is proposing additional language which states: Nothing contained in this subsection shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim." We have no criticism of the proposed expansion of this subsection to cover all suspected fraudulent losses. If passed, however, additional training of all claim representatives, but particularly those in SIU departments, would be required.

The Commission is also proposing a new section entitled "Disclaiming coverage" at §6.10. This new section would impose upon a carrier the duty to notify a claimant in writing as soon as determined that there was no policy in force or that it is disclaiming liability because of a breach of policy provisions by the policyholder. Specific reasons for disclaiming coverage are required. We have no objection to this subsection as it applies to situations where there is no policy in force and assume most carriers are presently notifying claimants in writing of such occurrences. Problematic, however, is the provision that a carrier must explain its specific reason for disclaiming liability because of a breach

of policy provisions by the policyholder. Typically, this would be a breach of the cooperation clause. This proposed section does not take into consideration the requirements of Syllabus Point 1 of *Thomas, supra,* which states that before an insurance policy will be voided because of the insured's failure to cooperate, such failure must be substantial and of such nature as to prejudice the insurer's rights. In addition to prejudice, the insurer must show that its insured willfully and intentionally violated the cooperation clause of the policy before it can deny coverage. *Id.*, Syl. Pt. 2; see also *Charles v State Farm Mut. Auto. Ins. Co.*, 192 W.Va. 293, 452 S.E.2d 384 (1994). Reliance upon this proposed rule change without the additional showings could thus subject a carrier to a first party "bad faith" claim. This additional demonstration of prejudice is set forth in proposed §8.3 which will be addressed *infra,* and we propose that this provision either 1) be deleted in its entirety or 2) amended to be consistent with applicable case law.

The Commission has also added a new section, §6.12 entitled "Responsibility for use of data" which is very problematic and may be impossible for carriers to meet.

This new section would again impose additional responsibilities upon carriers, specifically to demonstrate the accuracy of data used to establish the value of insurance claims including when a computerized database source is used. While at first blush it does not seem unreasonable that a carrier should be responsible for the accuracy of data, when it comes to the use of computerized databases provided by outside vendors, it imposes an undue responsibility on insurers to verify the data of others over which it presumably has no control. The use of computerized databases is on the rise with insurance carriers across all lines of coverage. Many carriers utilize Colossus® or similar software to evaluate personal injury claims and similar databases to evaluate medical bills and almost all carriers use NADA, Mitchell's or CCC® to estimate the value of automobile. This appears to be a trial-lawyer driven attack on the use of such databases such as the class action litigation we have seen across the country on this issue. We draw to your attention, however, that the West Virginia Insurance Commissioner has approved the use of many non-published data services, such as CCC® for the purposes of evaluating motor vehicle values and thus it must be presumed that carriers have met their burden of demonstrating the accuracy of data used in such approved databases. See Informational Letter No. 143. Previously, the responsibility to establish reliability rested between the vendor and the Commissioner and such responsibility should not be shifted to the carriers.

Moreover, to the extent an outside vendor has control of the underlying data in many instances and that said data changes constantly, it is highly prejudicial to the interests of any carrier to be held responsible for the accuracy of such ever-changing information. Presumably, a carrier is responsible for any data it maintains in-house for the evaluation of personal injury claims such as the baseline information of Colossus® or similar software. The Commissioner proposes to exempt any responsibility for data provided by any governmental entity unless the carrier is on notice of such inaccuracy and nonetheless continues to use the data.

This section, like many others, is silent as to when this information will be considered by the Commissioner, the burden of proof, discovery issues, the preservation

of trade secret or proprietary information as protected by *State ex rel. Johnson v Tsapis*, 187 W.Va.337, 419 S.E.2d 1 (1982), and the production of this information to claimants and/or their counsel contrary to marketing agreements and other objections of the vendors who may not have the right to intervene in any administrative process. Provisions for the protection of trade secrets similar to those found in §7.2 concerning "Official used car guides" should be inserted into this section if it is to be enacted. Additionally, several carriers have agreements with private vendors concerning notification and intervention rights and we would suggest that such vendors be immediately notified of this proposed rule change to the extent any vendor may wish to oppose such during the public comment period.

The Commissioner has also proposed a new section, §6.17, which prohibits carriers from compensating its employees, agents or contractors based upon savings from claim denials. While on its face, this does not appear to be objectionable, there could be corporate incentives that have claims payments as a component. A broad reading of this section may therefore invalidate these programs. Further, if an employee's eligibility for a bonus, incentive or other additional compensation program is based upon a level of claims handling that considers, directly or indirectly, claims payments, closings without payment, trade combined ratios, etc., such eligibility requirements may bring the incentive plans into question.

Section 6.18 seeks to limits information adjusters can utilize when dealing with unrepresented claimants and prohibits carriers from explaining the merits, or lack thereof, of retaining counsel or engaging a public adjuster. This is clearly aimed at Allstate's "Do I Need An Attorney?" letter, but some adjusters do engage in mathematical equations with unrepresented adjusters explaining that net recovery may be greater if a settlement is reached while the claimant is unrepresented. To the extent adjusters utilize this negotiation tactic, it must be curtailed if this subsection is enacted.

We have no objection to the proposed addition of §6.19 which would prohibit an insurer from deducting premiums owed from a claim payment.

Section §6.20 restricts an insurer's ability to request income information to only those claims involving a fire loss, loss of profits or loss of income. This obviously overlooks personal injury claims in which permanency is alleged and would thus deprive a carrier of the right to investigate if the claimant is in fact permanently injured or whether the claimant is engaged in some work activity thus defeating certain claims.

We have no objection to proposed §6.21 which would prohibit an insurer from requesting or requiring a claimant to submit to a polygraph examination unless authorized by the policy or state law or if the claimant gives written consent.[6]

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[6]This section permits the use of polygraphs or other truth detection devices if authorized under the applicable insurance contract. Any carrier wishing to utilize such devices may consider changing its policy language subject to approval by the Commission's Rates and Forms Division.

The Commissioner is proposing several additions to the rule concerning subrogation claims. We find the addition of any section concerning subrogation to be incongruent with the Unfair Trade Practices Act. The UTPA governs claim settlement practices. Subrogation is not by definition a claim settlement practice and thus should fall outside the purview of Series 14. We believe that insurers should argue that subrogation does not involve either a first party or third party claimant as defined by the rule and that any attempt to pursue subrogation is not a claim settlement practice. Thus, we propose that §6.22 be stricken in its entirety as beyond the subject of the UTPA and rules that may be promulgated thereunder.

Assuming for purposes of this analysis only, however, that subrogation claims are to be governed by this Series, we will nonetheless share our opinions concerning the proposed section.

First, the proposed section prohibits subrogation until a carrier has conducted a "thorough, fair and objective investigation as to whether subrogation is appropriate." While we have no objection to this preamble and presume carriers are conducting due diligence in this and other aspects of their business, we question its necessity in the rule. This appears to be an avenue for the subversion of the civil justice process whereby a defendant in a subrogation claim could file an administrative complaint with the Commission seeking its determination as to whether subrogation is appropriate rather than defending the suit at a court of law.

With respect to the actual requirements of pursuing subrogation, the Commission seeks to impose several new notification requirements which will require the creation of forms and additional training of claims personnel.

Section 6.22a would require an insurer to provide written notification to first party claimants as to whether the insurer <u>intends</u> to pursue subrogation. If not pursuing subrogation, the notification must include a statement that any recovery to be pursued is the "responsibility" of the first party claimant. We find the use of the term "responsibility" in any such mandated notification troubling since presumably a carrier is not pursuing subrogation because it has determined that recovery is unlikely. To indicate to an insured that it has a "responsibility" beyond contractual obligations is therefore misleading. This section would not apply if the carrier: 1) waives the insured's deductible; 2) no deductible applied to the claim under which coverage was paid; 3) the loss sustained does not exceed the deductible or 4) there is no legal basis for subrogation.

If pursuing subrogation, a carrier would now be required to include in any subrogation demand the insured's deductible. Moreover, §6.22b requires insurers to share subrogation recoveries. The manner of sharing recoveries, however, appears to be incorrect in its language. As written, the proposed subsection states: Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount." It seems the Commission intends to preserve the right of the insured to recover the full amount of the deductible; however, as written, an insurer must also presumably share subrogation recoveries above the deductible. This could result in a double recovery to the insured.

Moreover, the section does not address the made whole doctrine and again we would propose striking this subsection in its entirety. Alternatively, this clause should be rewritten to permit a proportionate sharing of any recovery up to the deductible but permit carriers to recoup 100% of any remaining subrogation recovery which is statutorily and contractually permitted, to include attorney fees and costs, if appropriate.

The proposed section also states that no insurer may deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency and then only permits the deduction on a pro rata share of the allocated loss adjustment expense. As written, it would be possible for an insured to be allocated legal and other expenses which would exceed the recovered deductible. This also interferes with any contract an insurer and/or insured may have entered into with outside counsel. Deductions should be pursuant to the fee agreement with the outside counsel or collection agency without regard to the carrier's internal allocated loss adjustment expense.

The Commission is also proposing the addition of a section indicating that no insurer may require a claimant to withdraw, rescind or refrain from submitting any complaint to the commissioner regarding the handling of a claim as a condition precedent to the settlement of any claim, §6.23. We object to the inclusion of this section as it would eliminate any ability of a carrier to settle a claim globally.

The Commissioner is also seeking to require additional information when claims are denied. Section 6.24 would require any notice rejecting <u>any element</u> of a claim involving personal <u>property</u> insurance to contain specific policy and claim number information and provide the claimant notice that the claimant has the option of contacting the Commissioner and requires a notice providing the physical and mailing address, telephone number and web site of the Insurance Commission. We question why this notice is required at all, but if so, why limited to personal property claims. This notice would be mandated and would be yet another form to be created by carriers in order to be compliant with these rules. Moreover, it seems to be an invitation to file administrative complaints over denials of any property damage claims to the Commissioner and we find no public policy reason why such claims are deserving of additional notices.

Standards for Prompt, Fair and Equitable Settlement Applicable to Automobile Insurance

The only proposed change to this paragraph is contained in §7.2-2E concerning conditioning deductions for automobiles. Conditioning deductions must be "reasonably based on a physical attribute that has the effect of decreasing the vehicle's value." To the extent this subsection deals with total losses of vehicles, it does not appear that this will be extremely problematic; however, the Commissioner fails to define the criteria for conditioning deductions. Taken in a vacuum of the universe of claims, taking a conditioning deduction from an NADA retail value may not fall within the "physical attribute" characterization.

Standards for Prompt, Fair and Equitable Settlement of Third Party Claims

The Commission is proposing the addition of a new section, specifically §14-8 which is by its title limited to third party claims and which applies only to property and casualty insurance contracts. This section is in addition to all other provisions of the rule. This section also requires action within ten (10) working days and imposes the additional duty in third party claims that upon receipt of a notice of claim, if the insurer has a "good faith belief that it is not liable for any payment," then the insurer must so notify the claimant, in writing. Such notice requires that the insurer furnish the claimant its policy number and deny the claim, setting forth the reason(s) therefor.

We obviously object to the restricted time frame. This new requirement may also require the creation of an additional form notice for such situations but is essentially no different than current claim handling requirements concerning the denial of a claim. Likewise, if the insurer is unable to verify coverage, the written acknowledgment to the claimant must so advise of this situation as per proposed §8.2a. The only troubling aspect to this proposed addition is the requirement that notice to a claimant must "request any additional information as may be needed to ascertain the existence or absence of coverage." From a practical standpoint, we question how a third party claimant might have any information that might assist an insurer in determining the existence of coverage for an alleged insured.

The written acknowledgment when coverage is known to exist also has specific information which must be included as per proposed §8.2b. When coverage is known to exist, the written acknowledgment shall inform the claimant that the insured has a policy which, to the extent of the insured's negligence and up to policy limits, provides coverage for property damage, including loss of use and any other out-of-pocket expenses reasonably attributable to the accident. This section seems limited to property damage claims and it is uncertain whether said notification is required in personal injury claims. This will require further clarification from the Commission.

Concurrent with this acknowledgment, the insurer must provide either a claim form or request by telephone or personal contact any pertinent additional information necessary

for the insurer to reach a final evaluation of the claim. Furthermore, within 10 working days of acknowledgment of the claim or receipt of the information requested when acknowledging the claim, the insurer must request any additional information required to process the claim. Finally, during the pendency of a claim if additional information is necessary, the insurer must request such information within 10 working days. This proposed section demonstrates little to no understanding of claim handling activities in that neither a claimant nor an insurer may know all information reasonably necessary to reach a final evaluation of a claim when a claim is first made. To the extent this proposed section is intended to apply to personal injury as well as property damage claims, certain elements of personal injury claims are not readily known when claims are first noticed, such as permanency, future medical expenses or any other element of future damages. To impose a 10 working day limit to request information that clearly would not be initially available is incongruent with prompt and efficient claim handling.

Similar to §6.10, the Commission is also proposing a new section with respect to an insurer's duties when a policyholder fails to cooperate with the processing of a claim. Pursuant to proposed §8.3, if a claimant has given notice of a claim, but has not received notice from the policyholder, then the insurer must within seven (7) working days of notice from the claimant, notify the policyholder that failure to give notice and to cooperate may result in the company disclaiming liability and the potential for personal liability. Please note that the time to provide said notice to the policyholder is even more restricted. Moreover, this proposed section mandates the creation of another form, one that shall be furnished the policyholder to permit the policyholder to detail the incident.[7] This subsection would not apply if the insurer accepts and documents a telephone or personal contact which has resulted in securing the required information. Despite this mandated notification, the proposed section concludes by stating: "No insurer may deny or fail to adjust an otherwise valid third party claim because of the failure of the insured to cooperate unless the insurer can prove the lack of cooperation is material, substantial and to the prejudice of the insurer." While this language tracks that of the *Thomas* and *Charles* opinions cited above, it still fails to include the requirements of Syllabus Point 2 of *Thomas* that the insurer must show that its insured willfully and intentionally violated the cooperation clause of the policy before it can deny coverage. We can also anticipate arguments from third party claimants that any attempts to disclaim coverage due to the policyholder's failure to cooperate in the investigation of the claim is contrary to W. Va. public policy and the Financial Responsibility statute.

Finally, the proposed amendment indicates that the section is not applicable to subrogation claims. We do not believe that subrogation should be included at all in this rule as per the discussion, *infra*.

[7]Note that proposed §8.3 only discusses disclaiming liability while proposed §6.10 discusses disclaiming coverage and liability.

<u>Third Party Administrative Complaints</u>

As per W. Va. Code §33-11-4a, the Commission is proposing rules governing the third party administrative complaint procedure. However, the proposed rule is contrary to the statute and does not provide the mandatory forms as required by W. Va. Code §33-11-4a(b)(1) nor has the Commission released proposed procedural rules as required. We have been advised that the Commission is currently preparing forms, but to our knowledge none have yet been made available although such complaints could be filed after July 8, 2005.

Proposed §9.1 requires an insurer to advise the Commissioner within 45 days after receiving notice of an administrative complaint of the status of negotiations with the claimant. This is a shorter time frame than permitted under W. Va. Code §33-11-4a(b)(4) and (5) which permits insurers 60 days after receiving notice of the complaint to attempt to "cure" the situation and so advise the Commission.

Proposed §9.2 also differs from the procedure set forth in W.Va. Code §33-11-4a(c). The proposed section includes contingencies that permit a claimant to control the administrative process which is arguably to the detriment of the insurer.

W.Va. Code §33-11-4a(c) states:

> If the third-party claim is not resolved within the sixty-day period described in subdivision (4), subsection (b) of this section through either the person's substantial correction of the circumstances giving rise to the alleged violation or an offer from the person to resolve the administrative complaint that is found to be reasonable by the Commissioner, the Commissioner shall conduct any investigation he or she considers necessary to determine whether the allegations contained in the administrative complaint are meritorious.

Proposed §9.2 states:

> If, within sixty (60) days after the insurer receives notice of a third party administrative complaint, the complainant has rejected all offers or has not responded to the last offer made, the commissioner shall determine whether the final offer was reasonable. If the insurer makes no offer during said time period, the commissioner shall determine whether an offer should have been made under the circumstances. ... For purposes of this subsection, an "offer" is a proposal to correct the alleged unfair claim settlement practice.

As you can see, the two sections differ. The Code is silent as to subsequent offers by the insurer and rejection and/or no response by the claimant. Our concern is that an insurer shall attempt to "cure" by making an offer and the claimant simply will not respond, thus triggering the hearing process. Permitting a claimant to invoke a hearing process by simply not responding is arguably permitting a claimant to act in "bad faith" by not fully

participating in the settlement process which should be against public policy, will cause the Commissioner to incur significant investment of her assets in investigating such complaints and is to the detriment of insurers. Moreover, this entire process will require the Commissioner to review every offer made by an insurer once a third party administrative complaint is filed simply to determine if the subsequent offer constitutes either a "substantial correction of the circumstances" as stated in the Code or whether the final offer was "reasonable" as stated in the proposed rule. Finally, the proposed rule is silent as to the second tier investigation permitted by the Code via the Consumer Advocate . Per W. Va. Code §33-11-4a(d), the Commissioner was granted the right to promulgate procedural rules for hearings. No proposed procedural rules have been released. Hearings, however, could begin as early as September 12 and it is unknown how those hearings shall be conducted, the information which may be considered, or the burden of proof, etc.

Damages are also addressed in the proposed new section which track, in part, the damages permitted in the Code. Proposed §9.4 outlines the two types of restitution permitted to a claimant, i.e., actual economic damages and noneconomic damages not to exceed $10,000.00 as set forth in W. Va. Code §33-11-4a(e)(2)(A)and (B), but fails to recite the remainder of (B) which prohibits restitution for attorney fees and punitive damages. We believe this should be incorporated into the language of the proposed rule to completely cite the pertinent Code provision.

Moreover, we would recommend that carriers urge the Commissioner to promulgate the mandatory forms for the filing of third party administrative complaints and to issue procedural rules relative to administrative hearings as per the Code.

<u>Training and Certification</u>

Finally, the Commissioner is proposing the addition of a section which would require certification of training concerning the proposed rule changes.

Section 10.1 would require every insurer to adopt and communicate to its claims agents written standards for the prompt investigation and processing of claims within 90 days of the effective date of the rule. Given that most insurers already have such written standards, we do not believe this will be an undue burden.

Section 10.2, however, will require immediate training and/or re-training of the claims force and potentially training of selling agents should an insurer elect such agents to accept notification of claims. Section 10.2 would require insurers to provide "thorough and adequate training regarding this rule" to all claims agents. Furthermore, insurers would now be required to certify that claims agents, except for licensed attorneys, have been trained regarding this rule and any revisions thereto.

Insurers must demonstrate compliance with this proposed new section by annual certification, in writing, under penalty of perjury. Individual licensees (i.e., adjusters) will be required to annually certify that he or she has read and understands this rule and any and all amendments thereto. §10.2a. Insurers must annually certify that: 1) its claims manual

contains a copy of this rule and all amendments thereto; and 2) that clear written instructions regarding the procedures to be followed to effect proper compliance with this rule and all amendments thereto were provided to all its claims agents. §10.2b. Moreover, insurers must provide training to insurance adjusters regarding this rule and annually certify such. A copy of the certification shall be maintained at all times at the principal place of business of the licensee, provided to the insurance commissioner only upon request. Annual certifications are required by September 1 of each year.

This proposed change will at a minimum require amendment to claim manuals to insert the new rules - if passed - and will require immediate training of claims personnel as well as the creation of forms for the annual certification. It is unclear who will or should execute the certification and we presume the carriers will make an internal decision as to the best person to certify that the carrier's claim manual contains a copy of the rule and all amendments thereto, that clear written instructions regarding the procedures to be followed were provided to all claim agents and that training regarding the rule occurred. While it is not clear, it is presumed such training must also be conducted annually before September 1 of each year in order to make subsequent certifications compliant with this section. To the extent claim manuals or best practices guides are available to adjusters on line or through an insurer's Intranet, we presume additions can be easily made by adding the new rules when adopted.

Training obviously will be a significant investment by the carriers and we can anticipate that the certification will be requested when the Commissioner is considering fining a carrier as now permitted by the Code. Given that a finding of a general business practice of violations of the Act or the Rule could result in a fine payable to the State of up to $250,000.00, we urge carriers to upgrade training to any adjusters who handle West Virginia claims to demonstrate appropriate education in an effort to thwart any finding of a general business practice of violating the Act or the Rule. This may be somewhat problematic for carriers who operate in a centralized environment but we strongly urge such carriers to immediately begin enhanced training to any adjusters who may ultimately adjust a West Virginia claim. We have invested significant firm resources into training of claims representatives and will continue to make such services available to you and your adjusters.

Overall, we believe that the proposed changes to the Rule are too restrictive, need significant clarification as to their application and are incongruent with claim handling in today's environment. We are available to discuss any of the proposed changes to the Rule with you in greater detail or to work with you in order to make your company compliant with these new rules should they become effective in this or amended form.

We are looking forward to working with you concerning these proposed Rule changes.

Sincerely,

MARTIN & SEIBERT, L.C.

BY: E. Kay Fuller
for Clarence E. Martin, III, Esq.

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #14

WRITTEN COMMENTS TO PROPOSED EMERGENCY LEGISLATIVE RULE TITLE 114, SERIES 14; PROPOSED BY INSURANCE COMMISSIONER

COMMENTS ON BEHALF OF THE WEST VIRGINIA PHYSICIANS' MUTUAL INSURANCE COMPANY
By: [signature]
Tamara Lively

Its: Executive Vice-President

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

Submitted July 25, 2005, to Victor A. Mullins, Esq., Associate Counsel to the West Virginia Insurance Commissioner

INTRODUCTION

The West Virginia Physicians' Mutual Insurance Company (Physicians' Mutual) was created by the Legislature in 2001 and strengthened by legislation in 2003 to ameliorate the medical liability insurance crisis in West Virginia. The Legislature provided initial capital and structure for its creation. The goal is to provide comprehensive medical liability insurance coverage for the majority of physicians in this state at an affordable rate. The further goal of the legislature is to control the acceleration of premiums through tort reforms. One of the key tort reforms was the elimination of third-party bad faith litigation against insurers for alleged violations of West Virginia Code § 33-11-4(9).

The Physicians' Mutual is now a viable company with more than 1600 insureds. It is meeting the legislative objectives of providing quality coverage at a competitive price. It is critical that any legislative rules which impact the Physicians' Mutual's ability to provide coverage be carefully crafted so as not to unintentionally destroy its fiscal integrity.

COMMENTS

The proposed rule does not and should not apply to third party bad faith actions arising from medical professional liability claims. The Physicians' Mutual respectfully disagrees that there is statutory authority to draft rules relative to third party bad faith actions derived from medical liability claims.

First, West Virginia Code §55-7B-5(b) is silent on whether claims may be filed with the insurance commissioner. The statute prohibits third-party lawsuits derived from medical professional liability claims. Further, West Virginia Code § 33-11-6(i), as amended by Enr. Comm. Sub. S.B. 418, effective July 9, 2005, specifically states the following: "The provisions of section four-a of this article [§ 33-4a] and subdivision (e) of this section [§ 33-11-6(e)] **do not apply to medical professional liability insurance claims** pursuant to article seven-b, chapter fifty-five of this code...."

Chapter 33-11-4a (Enr. Comm. Sub. S.B. 418) which creates an administrative process for third-party claimants and gives the Commissioner authority to promulgate emergency rules, must be read *in pari materia* with Section 6(i) of Article 11. "Statutes which relate to the same persons or things, or to the same class of persons or things, or statutes which have a common purpose will be regarded *in pari materia* to assure recognition and implementation of the legislative intent." Syl. pt. 5, in part, *Fruehauf Corp. v. Huntington Moving & Storage Co.*, 159 W. Va. 14, 217 S.E.2d 907 (1975). Applying the statutes as written, there is no clearly announced authority for third party administrative proceedings to include third-party claims derived from medical professional liability claims.

Assuming the Commissioner is advised of some basis in law for such rule-making, then, the Physicians' Mutual would request that the Commissioner proceed to develop a separate set of rules crafted to govern third-party claims arising out of health care-based litigation which recognizes the prohibitions contained in section 6(i) of Article 11 and the special circumstances discussed below. The Physicians Mutual respectfully requests that the Commissioner appoint a committee of knowledgeable persons to work with her in drafting appropriate rules. The Physicians Mutual would be willing to assist in such an endeavor, if there is a legal basis for such a proposed rule.

Second, there is no need for emergency rules in this particular third party area as the prohibition against medical liability derived third-party lawsuits has existed for four years, and on information and belief, it is understood that no claims have been filed with the Insurance Commissioner.

Third, assuming that the Commissioner may draft rules for third party claims derived from medical liability insurance litigation, then much like automobile litigation, medical liability third party claims have their own unique set of issues, evidence and concerns. The Commissioner has proposed a specific section of rules for third party claims arising out of motor vehicle accidents (114-14-8). Medical liability-derived third party claims need similarly specialized rules. These third-party claims will necessarily involve expert witnesses on medical issues, among other unique concerns. Lay people cannot practice medicine by opining either that liability was reasonably clear or the cost of correcting medical injuries. Lay people (insurers and lawyers) work from that data but for a hearing examiner to make a good faith determination that a settlement offer was unreasonable, he or she will have to obtain medical, professional assistance. The Physician's Mutual would recommend the Insurance Commissioner work with a group of interested parties to craft a workable rule.

Fourth, the Physicians' Mutual is a small company with limited staff. Holding the mutual to ten working days to respond to various items provided in the emergency rule is to either increase overhead by requiring additional staff or to put the Physicians' Mutual at risk for multiple claims simply because the staff

person was out of town or the agent was slow in getting notice to the staff person.

Fifth, the prohibitions set forth in section 6(i) of Article 11 must be clarified within any emergency rule proposed under the unfair trade practices provision.

***

The Physicians' Mutual proposes to clarify that the Series 14 (114 CSR 14) rule does not apply to medical professional liability insurers.

114 CSR § 14-1.1(c) should be modified as follows in italics:
(c). This rule applies to all persons and to all insurance policies and insurance contracts except Workers Compensation Insurance *and Medical Liability Insurance.*

Also, the definition of third party claimant should be clarified as follows:
114.14.-2.8 "Third Party Claimant" means any individual, corporation, association, partnership or other legal entity *excluding Workers Compensation and Medical Liability claimants,* asserting a claim against any individual,... [rest is ok]..

Alternatively, if the interested parties want the first party rules to apply, then the Physicians' Mutual would recommend that 14-1.1(c) remain as proposed by the Commissioner but that 14.-2.8 must be amended as we have proposed.

Sixth, The proposed change from 15 working days to 10 working days appearing *seriatim* in the proposed rule is untenable for the reasons stated above. The following sections should be either retained at 15 working days or made 15 working days:

Strike all proposed modifications to the existing rule and all new sections that change the time period from 15 (fifteen) days to 10 (ten) days, or create a ten working day period:

5.1 [strike suggested change to ten days]
5.2 [strike suggested change to ten days]
5.3 [strike suggested change to ten days]
5.4 [strike suggested change to ten days]
6.2 [strike suggested change to ten days in 2 places]
6.3 [new language: change ten working days to fifteen working days]
6.7 [strike suggested change to ten days]
8.2 [new language: change ten working days to fifteen working days]
8.2 b. [new language: change ten working days to fifteen working days in 2 places]

Seventh, The drafting of Series 14, section 6 regarding settlement and "unreasonably low offers", even if not applicable to medical liability claims, is troubling for the following reasons:

1. The section does not specifically state it only applies in third-party claims except for the reference to the commissioner.

2. If the advice of counsel is a factor in determining unreasonably low offers, then the attorney-client privilege may be lost whenever a person sues their carrier. There are duties that run between the attorney assigned to defend the insured and the insurance company, which may include providing a suggested settlement range; and duties which run between the insurer and its corporate counsel. The disclosures, per case law are governed by complex principles of privilege and quasi-privilege. See, e.g., *State ex rel. Allstate v. Gaughan*, 508 S.E.2d 75 (W.Va. 1998); *State ex rel. Medical Assurance v. Recht*, 583 S.E.2d 80 (W.Va. 2003); and *State ex rel. Brison v. Kaufman*, 584 S.E.2d 480 (W.Va. 2003).

Anything provided the Insurance Commissioner will be discoverable through a WV FOIA. Disclosure through FOIA could compromise a defendant's case, which may lead to higher settlement values and resulting premium increases.

The Physicians' Mutual would propose the following changes *in italics* to avoid waiver of all attorney-client communications on issue of unreasonably low offers, and to create objective criteria. The creation of objective criteria would be particularly critical to medical professional liability claims but is useful for any third party claimants.

14.-6.4 Offers of settlement. – In any case *where both parties stipulate that* there is no dispute as to coverage and liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions. If the claim presented is greater than policy limits, then the claimant must be so advised. Offers must be calculated in third party claims in the same manner as would be used if the claim were made under a first party coverage by one of its insureds.

14.-6.5 Unreasonably low offers. – No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. *In third party administrative complaints, t*he commissioner shall consider any evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

a. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim and any other evidence to rebut the claim, including but not limited to the opinions and testimony of experts;

b. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

c. The extent to which the insurer considered the advice of its claims adjuster as to the *range, if any* of damages *calculations*; [*note: the word "amount" has been deleted]*

d. The extent to which the insurer considered the likelihood of recovery in excess of policy limits; [*note: the phrase "advice of counsel regarding"has been deleted]*

e. The procedures used by the insurer in determining the dollar amount of property damage;

f. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

g. *Independent expert opinions on medical evidence and damages calculations; and [note: this is new text for g.]*

h. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made. *[note: letter "h" has been added]*

Eighth, the Commissioner's proposed amendments to the rule's penalty provision should be amended to capture the exclusion of MPLA claims specifically stated in § 33-11-6(i).

The Physicians' Mutual would propose the amendments as set forth in *italics:*

14.-12.1 Penalty. – Any person who fails to comply with any provision of this regulation shall, after notice and hearing, be found to be transacting insurance in an illegal, improper or unjust manner. The commissioner may, pursuant to section eleven, article three, chapter thirty-three, sections six, seven and eight, article eleven, chapter thirty –three and section twenty-five, article twelve, chapter thirty-three of the Code of West Virginia of 1931, as amended, refuse to renew, or may revoke or suspend the license of any such person or, in lieu thereof, the commissioner may, at his discretion, order such person to pay to the state of West Virginia a penalty in a sum not exceed that imposed by said sections of said code, and the commissioner may, pursuant to section eleven, article two, chapter thirty-three of said code, order such person to discontinue such illegal, improper or unjust transaction of insurance and to adjust and pay obligations as they become due*; however the insurance commissioner as*

prohibited by section six-l, article eleven, chapter thirty-three of said code shall not impose any penalties or take any actions against medical liability insurers.

Ninth, the Physicians' Mutual joins in the comments prepared on behalf of the West Virginia Insurance Federation to the extent those comments apply to medical liability insurers and claims arising from such liability insurance.

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TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #15

Mark D. Davidson
Director of Legislative Affairs
Office of Government Relations

On Your Side℠

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

July 20, 2005

Mr. Victor A. Mullins
Associate Counsel
Legal Division
West Virginia Insurance Commission
1124 Smith Street
Charleston, West Virginia 25301

Dear Mr. Mullins:

I am writing to respond to the proposed Unfair Trade Practices rule, 114CSR14 posted recently on the Department's web site and open for comment through July 23, 2005.

Detailed comments to the provisions of the rule are attached, but it is clear that, taken as a whole, it would be impossible for Nationwide to comply with its provisions and maintain our contractual relationship with our policyholders, whose coverage might be involved with a third party claim.

The rule in many cases equates our legal duty to a third party claimant with our legal obligations to a policyholder. In addition, the time lines uniformly specify ten working days for each step of the claims process except where only seven days is specified, each unreasonably burdensome.

As presented, the rule will dramatically increase the costs of processing every claim, in addition to imposing extraordinary burdens for handling third party claims.

It would appear that the rule intends to create by administrative process the very system repealed by the West Virginia legislature in S.B. 418, a system plagued by unreasonable costs, unnecessary process and unpredictable results. The cost savings anticipated by, and granted to, the premium payers of West Virginia by Nationwide will be seriously jeopardized by the provisions of this proposed rule.

Finally, the proposed rule process would also be extraordinary as the most burdensome administrative bad faith process in any insurance department in the country.

We would ask that a task force of insurance professionals and interested parties meet with you and others in the Department in the near future to design a fair and predicable process for hearing and resolving third party complaints.

Sincerely,

Cc: The Hon. Jane L. Cline
Mary Jane Pickens

One Nationwide Plaza, 1-27-09
Columbus, OH 43215-2220
Tel 614-249-4889

§114-14-2 Definitions

2.14 A new term "Egregious Act" is added and defined as "conduct that is clearly irresponsible, fraudulent, or malicious and reckless, consisting of a single act, whether or not part of a pattern of unfair claim settlement practices. Irresponsible conduct is simple negligence that should not rise to the standard of 'egregious' behavior. We would object to a single negligent act imposing an unfair trade practice.

§114-14-3 File and Record Documentation

3.1 The language of this subsection could be read to include work papers and other documents protected by attorney/client privilege. We would request adding the words 'under subpoena' following 'duly appointed designee'.

§114-14-4 Representations of Policy Provisions and Benefits

4.1 We question why it is necessary to strike a key provision of the NAIC model unfair trade practices act rule language. The replacement language goes far beyond the model provision, by requiring the disclosure to a claimant provisions of '*any* insurance policy issued by that insurer that may apply...' As structured, this provision could include coverage from several insurance products not immediately at issue with regard to the claim. It is unreasonable to require 'full disclosure,' particularly since a court could later find coverage not intended in a contract for claims circumstances that were not contemplated when the policy was underwritten. Such a finding could retroactively put the carrier in violation of this rule. Further, we would suggest, in the second sentence, deleting the words 'might reasonably be' and inserting 'are' for clarity.

4.4 This new provision clearly puts a carrier in a no-win position as only a time specified in a policy is acceptable, but any time provision so stated can easily be ruled ' unreasonable' and stricken upon review. Essentially, the rule means there can never be a late claim and, potentially, no triggering of a statute of limitations. We request this provision be removed. Additionally, failure to require prompt notification of a claim facilitates insurance fraud.

4.5 Since most settlements are negotiated orally, this provision would require additional writings that will add layers of expense and processing time. In addition, any settlement offer that omits coverage later determined to exist by department or court interpretation of a contract where no such coverage was intended nor premiums charged will be deemed *de facto* misrepresentations. The statute now requires insurers to include with claim payments a statement that identifies the coverage under which the payment is being made. The proposed rule seems to extend that duty to third-party claimants, to whom an insurer has no contractual obligation; even in the first party context, however, the proposed rule makes a partial payment a fraudulent act [illegible]

114-14-5 Standards for the Acknowledgment of Pertinent Communications

5.1 This provision reduces a carrier's response time by five working days, a 33% reduction in processing time, creating an unreasonable burden. The new language of this provision is such that an unintentional mistake on the part of an agent results in a violation of the rule by the carrier, establishing a veritable trap for a company that, otherwise, has done everything else correctly.

5.2 Again, there is the reduction of time available to process from fifteen working days to ten. In addition, changing the trigger date from date of receipt to date appearing on the inquiry poses an additional reduction in the time available to provide a response. The new language in this provision also requires provision of copies of 'any documentation' which could easily include information protected by federal and state privacy acts or by attorney/client privilege. The subsection extends its reach to licensed agents whose files contain similarly protected information, but whose operations are not under direct control of the insurer.

5.3 Again, reduction of time available to process from fifteen working days to ten.

5.4 Again, reduction of time available to process from fifteen working days to ten.

§114-14-6 Standards For Prompt Investigations And Fair And Equitable Settlements Applicable To All Insurers

6.1 It appears that this subsection could apply to both first party and third party claims. We object to equating the duty of an insurer to a third party claimant to that due a first party policyholder. The term 'unreasonably delay' is not defined.

6.2 Again, reduction of time available to process from fifteen working days to ten. In addition, a carrier's agent, either exclusive or independent, who fails to put a notification in writing is likely to encumber the carrier with an unknown and unknowable violation of the rule. Since the terms 'claimant' and 'first party claimant' are used in this subsection, the expectations of insurers are ambiguous.

6.3 This is a new provision setting the 10-day standard for communicating a denial or written offer of settlement. Since it is not possible in each case to make a written offer of settlement within ten days, we would suggest this provision be revised to require a carrier to simply accept or reject the claim in writing at the conclusion of its investigation.

6.4 The language added at the end of the subsection raises a carrier's legal duty to a third party claimant to that due its policyholder. Again, requiring the disclosure of policy information is likely to violate federal and state privacy statutes.

6.5 Subsection 6.5 is contrary to the recently enacted law by establishing a subjective standard of an 'unreasonably low offer' as an unfair trade practice and contains other substantive problems as well. We respectfully request a deletion of the entire subsection.

6.6 Requires every denial to be in writing, presenting an unreasonable burden and opportunities for technical violations of the rule, particularly through an error by an agent, that should not constitute a pattern of practice. We request a reinstatement of the original 6.4, with the addition of a clarification that answering a question of coverage is not a 'denial' nor is a claim that is less than a policy's deductible.

6.7 Again, the subsection reduces the time available to process from fifteen working days to ten. This subsection again equates a third party claimant with a policyholder with whom the insurance carrier has a contractual relationship. Further, the subsection appears to waive an insurer's requirement that a properly executed proof of loss be submitted to pursue a claim. A notice requirement should not apply to claims in litigation.

6.10 The new subsection again conflates the legal status of a third party claimant with that of a contractually bound policyholder, to which we again object. In addition, the provision that the insurer notify a (first party) claimant in writing.....that it is disclaiming liability.... instead of coverage as provided by a policy approved by the West Virginia Department of Insurance. We would also request the addition of the words 'to its policyholder' at the end of the last sentence.

6.12 a. "Insurers are responsible for the accuracy of data used to establish the value of insurance claims." This subsection imposes an unreasonable burden on an insurer for all information received from vendors, members of the medical community, body shops, parts vendors and others. As any user of information, insurers must rely on the good faith of those providing data for its accuracy. Further, some data is secured from vendors pre-approved by the Department as adequately accurate for the purpose. In addition, insurers are given no standard of compliance. How often must data be tested, etc.? Counterintuitive to the first part of this subsection, the last sentence would require an insurer to accept as valid any information presented by a claimant, regardless of documentation, and again equates a third party claimant with a first party policyholder.

b. This subsection, however, establishes a trap for insurers who rely on government provided data and miss a subsequent retraction or revision of that data. It could be later argued that the insurer 'knew or should have known' that the information was inaccurate. [illegible]

6.17 This subsection would require an insurance carrier to prove the negative – that it did NOT compensate any of its employees based on savings generated by 'denying the payment of claims' and would clearly authorize fishing expeditions to discover compensation schedules totally unrelated to the resolution of a claim. In addition, the subsection would also call into question any performance bonus that is a standard component of industry compensation plans. We request this subsection be deleted.

6.18 This subject of this subsection has already been settled by the West Virginia Supreme Court of Appeals in the Allstate v. WV Bar Association case and is not needed in this rule.

6.20 The proposed subsection will greatly enhance the ability of those pursuing fraudulent claims to shield from investigators pertinent information that could help document insurance fraud, which extends well beyond 'fire loss or ... a loss of profits or income'.

6.22 This subsection will increase the cost of insurance claims, grant to claimant's unintended benefits and effectively disallow provisions of insurance contracts already approved by the Department of Insurance. In the case of third party claimants, this subsection again elevates the position of such claimant above the position of our contractual partner, the policyholder.

6.24 This subsection creates a legal trap for an insurer by the standard of 'any notice rejecting **any element** of a claim' must contain the listed information. Informal or verbal comments would not be allowed, thereby increasing further the cost of processing every claim.

114-14-8 Standards for Prompt, Fair and Equitable Settlement of Third Party Claims

8.1 Contracts for insurance do not 'afford' coverage for claims by third parties but provide coverage to our first party policyholders.

8.2 It is not possible to complete a fraud investigation within ten days to be able to respond positively that an insurer is 'not liable for any payment'. b. It is a violation of policyholder confidentiality to disclose details of a policy's coverage to third parties. Similar to other sections, the requirement to perform all communications tasks outlined in this subsection by not longer than 10 working days is not possible. c. The time line of seven working days in this subsection is unrealistic. Further the intent of this subsection puts the insurer in an adversarial position with respect to its insured, possibly setting the stage for a first party bad faith lawsuit. An insurer's legal obligation is to mount a vigorous defense on behalf of its policyholders, not a third party claimant.

1114-14-9 Third Party Administrative Complaints - The substance of this section is unnecessary as its provisions are already contained in the statute.

114-14-10 Training and Certification

This section requires a written claims processing manual, thereby creating written material that can be challenged before the Commission or later in court. In addition, the specific training, its nature, frequency, shortcomings, errors, omissions, et al, presents opportunities for actions to harass an insurer into unjustly settling meritless claims. Requiring insurers to certify, under penalty of perjury, to standards of behavior and be responsible for interpretive changes in this rule as are likely, from time-to-time, to be derived from administrative rulings and court opinions, whether widely disseminated or not, essentially guarantees violations of the rule. We request this section be deleted.

Finally, these proposed rules should include provisions excluding all information required by them as confidential and not subject to the Freedom of Information Act. Similarly, all documents produced to the Office of the Insurance Commissioner in connection with the investigation of claims should not be public records subject to FOIA requests merely because they are delivered to the Office.

Thank you for the opportunity to comment on the proposed rules. We would welcome the chance to further discuss these comments or provide any clarification you might seek.

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #16

West Virginians
Insuring West Virginians

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By Hand-Delivery
Victor A. Mullins
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RE: Comments – Proposed Administrative Rules
Title 114, Series 14

Dear Mr. Mullins

On behalf of the West Virginia Association of Insurance Companies (WVAIC) please accept this letter affirming the comments of the West Virginia Insurance Federation in their letter dated July 25, 2005 signed by Jill C. Bentz, Federation President.

The WVAIC and its member companies actively participated in developing these comments and while we are a member of the Federation and a member of our Association is the Federation Chairman, we wanted to make sure the Insurance Commission was aware of our participation and concern regarding the Administrative rule changes listed above.

Of special concern is the change in the numerous time deadlines moving response times from fifteen (15) to ten (10) days. As many of our membership companies are small and have limited staffing which perform multiple duties, constraining the time deadlines will be unreasonably and burdensome and seems to again put West Virginia into a position of having one of the most restrictive insurance environments in the United States. This is the same environment we all have worked hard to improve with the passage of Senate Bill 418 and similar legislation.

On behalf of the membership of the WVAIC, I thank you for the opportunity to comment on this most important issue. If you have any questions or need additional information the membership is available to meet or discuss this issue. Please feel free to contact me at the number above or via my cell phone at 546-8501, at your convenience.

Sincerely,

Mark E. McCallister

Mark E. McCallister
President

RECE[illegible]
JUL 25 2005

cc: Jane L. Cline, Commissioner
Mary Jane Pickens, Chief [illegible]

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #17

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July 25, 2005

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

BY HAND-DELIVERY
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Charleston, West Virginia 25301

RE: Comments to Proposed Administrative Rules
Title 114, Series 14

Dear Mr. Mullins:

These comments to the proposed amendments to 114 CSR 14, relating to Unfair Trade Practices, are submitted on behalf of the West Virginia Insurance Federation ("WVIF"), the trade association for property and casualty insurance companies doing business in West Virginia.

There are two general issues that are easily apparent from a review of the proposed rules that seem incongruent with both the purpose of Senate Bill 418, the legislation underlying these proposed rules, and very fundamental principles of first and third party insurance relationships.

First, much to the WVIF's surprise, numerous time deadlines have been changed from current law, creating more stringent time requirements for insurers. Specifically, proposed Sections 5.1, 5.2, 5.3, 5.4, 6.2, 6.3, 6.7, and 8.2. change certain time deadlines from 15 to 10 days. Of utmost concern is that this change is inexplicable; there does not appear to be any requirement or basis for this change in any of the underlying legislation. These shortened time frames are unreasonably restrictive and burdensome on insurers.

In reviewing other states' similar time deadlines for responding to complaints, for example, other states generally permit 15 to 30 days for such responses. If adopted as proposed, West Virginia's 10-day deadline likely would be the shortest time period of any state in the country – a position that concerns many insurers in that it promotes a more restrictive environment than other states.

Second, the WVIF does not believe that insurers can reasonably and in good faith comply with the rules as proposed and maintain their lawfully required contractual duties to their

insureds. An insurer necessarily owes a heightened duty to its own insured, and much of the proposed language inappropriately interchanges the duties and standards for first and third party insureds. A first party insured is not a third party claimant, and the distinctions are many and of significant meaning. These proposed rules do not adequately distinguish between the two.

In addition to these general themes, member companies, consisting of more than 80 percent of West Virginia's private passenger automobile and homeowners insurance market, offer the following comments, by section, concerning the proposed language:

1. **Sections 2.2, 2.3, and 2.8.** Together, these Sections define "claimant", "first party claimant" or "insured", and "third party claimant" with such ambiguity that they easily could be confused. Specifically, the definition of "claimant" proposed in Section 2.2 could give rise to arguments for damages under the Unfair Trade Practices Act ("UTPA") for family members or others who do not actually qualify as a first or third party claimant. Additionally, the definitions contained in proposed Sections 2.2 and 2.8 could result in "third parties claimants" qualifying as "first party claimants" and improperly entitling them to damages only afforded to first party claimants. The WVIF, therefore, recommends clarification of the definition of "claimant" and the addition of language to the definitions of "first party claimant" and "third party claimant" instructing that the first party claimant pays premiums and that the third party claimant has a claim against an insured for which it did not pay the premium.

2. **Section 2.14.** The definition proposed for "egregious act" includes conduct that is "clearly irresponsible", which is a lower legal standard and contemplates unintentional, negligent acts. Indeed, "clearly irresponsible" conduct is simple negligence and, therefore, implies a standard that is lower than "gross negligence." It is not fraudulent, malicious or reckless conduct, which is heightened conduct that exposes the actor to punitive damages. The inclusion of "clearly irresponsible" conduct in the first sentence of the definition is inconsistent with the statement in the second sentence that "simple negligence" is not an egregious act and, importantly, appears to be inconsistent with the UTPA. The term "clearly irresponsible" should not be included in this definition.

Similarly, the term "gross negligence" is not egregious but could be implied as such under this proposed Rule.

Finally, neither the definitions nor any other section of the rule indicates who will make such findings, at what stage such findings will be made, and which party will bear the burden of proof. In addition to not identifying who has the burden of proof, the rules do not define the burden of proof that must be satisfied. In light of the fact that the definition of "egregious act" contemplates fraudulent acts, the appropriate standard of proof is "clear and convincing", and the WVIF suggests the adoption of that standard.

3. **Section 3.1.** This Section relating to file and record documentation by the insurer does not contemplate documents and communications that may be subject to the attorney-client privilege.

4. **Section 4.1.** The proposed Rule requires insurers to disclose to a first party claimant "or beneficiary," *all* ("pertinent" has been deleted) benefits, coverages, time limits or other provisions of any insurance policy that may apply to the claim. When "additional benefits" might reasonably be payable upon receipt of additional proofs of claim, the insurer *shall* immediately communicate this fact to the insured and "cooperate with and assist the insured in determining the extent of the insurer's additional liability."

Certain portions of this proposed rule seem limited to first party claims and if it is the intent of the Commissioner to so limit this section to first party claims, the WVIF recommends that the introductory statement delete "or beneficiary" or be amended to more fully define the scope of this section's application.

Furthermore, in situations where certain coverages are not triggered by the facts of the loss, most insurers are not disclosing said coverages to claimants and, thus, this new rule may require a change in claim handling procedures. This is also problematic in instances where an insured may be presenting a UM or UIM claim. At the time of the initial contact with the insured, the claim representative may only have available to him or her the declarations sheet or other immediately available summary policy data and may not have access to selection/rejection forms or other similar information that might demonstrate that UM or UIM coverage is either available or may be available in a higher amount. Imposition of this new requirement would, therefore, be impossible for claim representatives to follow without making such underwriting documentation available to the claims department without the need for a special or more detailed request requiring significant, additional time.

Should this proposed language apply to third party claims, it requires the disclosure of an insured's policy limits, which is obviously problematic. Although the West Virginia Supreme Court of Appeals has overruled an insurance carrier's arguments that revealing such nonpublic personal financial information constitutes a violation of the Gramm-Leach-Bliley Act, the WVIF nonetheless believes that an insured must first consent to the release of policy limits information in the claim process before suit is filed and the information is subject to discovery. If this section applies to third party claims and is intended to require the disclosure of an insured's policy limits, then the WVIF recommends that the section be amended to specifically identify such so as to protect against future first party claims when such information is revealed.

Particularly troublesome is the affirmative obligation the rule seeks to impose on the part of the insurers to actively disclose all coverages and benefits. This directly contradicts existing law. As our Supreme Court has stated, "[l]ooking at our own precedent, we can find no authority requiring an insurer to notify its insured of available coverage following notification of a loss or to advise its insured as to the limits of such coverage." *Kronjaeger v, Buckeye Union Insurance Co.*, 490 S.E.2d 657, 673 (W. Va. 1997). The Court in this case determined that there is no affirmative duty to advise a first party insured of the existence of underinsured motorist coverage: "[t]o require an insurer to inform an insured about coverage the insured him/herself purchased is nothing short of absurd." *Id.* at 674. Clearly, this rule runs afoul of existing law.

Practically, this rule, if adopted, identifies neither the process nor the extent to which insurers will be required to make such disclosures. For example, will companies be required to provide such information by letter to their insureds, or will oral communications be sufficient?

Requiring companies to provide information about coverage that "may apply" or about benefits that "might reasonably be payable" is vague, giving companies little guidance on what should be disclosed or, in the alternative, requiring companies to disclose information that may or may not be applicable in order to be overly inclusive in an effort to comply with the rule. Ultimately, this could lead to insureds' confusion and misunderstanding about coverage and benefits. This same language, coupled with the vague disclosure requirement of "time limits or other provisions of any insurance policy", suggests that the insurer could very well become a professional insurance advisor to a first party claimant. Clearly, this is not the intention of the proposed rule or the underlying legislation.

The term "immediately" when used to refer to the time frame within which such information should be communicated to the insured is ambiguous and should not, therefore, be used as a standard of conduct as it is currently written.

This section similarly ignores the fact that some portions of the claim file may be protected by the attorney client privilege.

Further, this section begins the curious changing of the word "shall" from the existing permissive use of the word "may" when addressing the activities of insurers. This inexplicable change in terminology effectively lowers the burden of proof for the complainant. This change of terminology also appears in at least the following proposed sections: 4.3, 4.6a and b, 6.5, 6.6, 6.9, 6.15, 6.16, 6.17, 6.18, 6.19, 6.20,6.21, 6.22, and 6.23. Importantly, however, the word "shall" has not been changed in sections where an affirmative obligation is imposed upon an insurer (e.g., proposed Sections 5.2, 5.3, 5.4, 6.1, 6.2, 6.3, 6.4, 6.7, 6.8, 6.11, 6.12, 6.13, 6.14, 8.2a, 8.2b, and 8.3). It seems unbalanced to require strict compliance with rules by insurers but

does not similarly require the complainant to show an intentional violation of the rules, merely a negligent violation.

Finally, the proposed section deletes language, such as the word "pertinent," that is National Association of Insurance Commissioners ("NAIC") model language, which seems inconsistent with recent efforts to bring West Virginia's insurance market into the mainstream as well as previous, unrelated efforts to adopt NAIC model language into West Virginia's statutory framework.

5. **Section 4.4.** This proposed rule essentially provides that there can never be a "late claim" unless the policy contains a specific deadline for making a claim. This raises concerns about late notice and the resulting prejudice to the insurer due to untimely filing of claims. It also suggests the concern that this portion of the Rule could conceivably be interpreted to supplant an applicable statute of limitations.

This is inconsistent with the requirement imposed by most policies that have previously been approved by the Office of the Insurance Commissioner. For example, at least one member company has policy language which requires the insured to provide notice of the loss "as soon as reasonably possible". Would this policy language qualify as a "time limit" under the proposed rule? The WVIF respectfully urges clarification of this language.

6. **Section 4.5.** The proposed language raises the question of whether a written explanation will be required for all checks issued. Under the proposed rule, if an insurer makes a partial payment of a claim, which may be less than the amount claimed on the proof of loss, then the insurer will have to explain why it is paying less than the amount in the proof and the absence of an explanation will automatically be deemed a misrepresentation. This rule appears to have no real value other than to cause potential "misrepresentations." Indeed, it seems to be common sense that so long as the partial payment is not improperly designated as a full and complete payment, such an explanation should not be necessary.

For instance, a partial loss check written to an insured at the scene of a fire loss in order to get money into the hands of the insured as soon as possible would constitute a "payment" that, "without explanation, does not include all amounts which should be included according to the claim filed by the claimant." Under the proposed rule, this would be a communication that misrepresents a pertinent policy provision. We do not believe this is an intended or desired result.

The language "all amounts which should be included" is equally troublesome. It is vague and ambiguous and does not contemplate situations involving disputes as to settlement value.

Moreover, the West Virginia Supreme Court of Appeals held in *Miller v. Fluharty*, 500 S.E.2d 685 (W. Va. 1997), that an insurer must explain the basis of all settlement offers made in first party claims if rejecting a demand within policy limits. Such duty has never been extended beyond first party claims, and this proposed subsection would inappropriately expand such duty.

7. **Section 5.1.** This is the first of many proposed rules in this Series that reduces time requirements from 15 working days to 10 working days. Decreasing the time frame for acknowledgement of notices of claims from 15 to 10 working days creates a significant additional burden on claims handling personnel and appears to serve no legitimate purpose, particularly where violations of this time frame are considered to be acts of "bad faith."

While the bulk of all claims is acknowledged within just a few business days, there are situations where a claim is reassigned, an agent delays forwarding a claim for some reason, or individuals are out of the office due to illness or vacation. In such situations, the extra five working days provides adequate time to handle the claim within a reasonable and efficient time period, but 10 days would cause occasional difficulties.

Additionally, the synergistic effect of dramatically shortening multiple time frames within which the insurer must take some action is significant. It seems that there is little or no reason to create unnecessary "traps" for claims handlers by unnecessarily shortening these time frames.

The fact that claimants can submit claims to agents, as well as submit claims directly to the company, underscores the need to retain the existing 15-day window for handling claim.

8. **Section 5.2.** This proposed rule requires responses within 10 working days from the date appearing on the inquiry, rather than 15 working days of receipt of the inquiry from the Office of the Insurance Commissioner. Not only does the shortening of the time period concern insurers, but the change from "receipt of the inquiry" to the "date appearing on the inquiry" significantly reduces the insurer's ability to respond even more.

The U.S. Mail system can be unpredictable, and even outgoing mail inadvertently may lay on a desk before deposited in the mail. This proposed change from "receipt of inquiry" to "date of the inquiry" is fraught with the potential for a finding of a violation of the UTPA purely as a result of the unpredictable mail system. This can be easily cured by changing the language to "receipt of the inquiry", which is the trigger for other actions contained within this Series of rules.

Also, these inquiries often concern complex or fact specific issues of whether the insurer had little or no knowledge until receipt of the inquiry. It is questionable whether present staff in insurers' home offices that respond to such inquiries as part of their duties can satisfy this 10-day requirement. Large companies need the current additional five working days to ensure the proper claims personnel handles the claim while small companies fear the prejudice they could suffer from the two week absence of the single person charged with claims handling in its company. This change seems unnecessary.

Regarding such inquiries, the deletion of the language "respecting a claim" appears to broaden the authority of the Insurance Commissioner under this rule by permitting the Commissioner to inquire about any issue, not just claims. This, too, seems unnecessary and not intended by the underlying legislation.

This proposed section also seems to require multiple responses from producers, the insurer, and any licensed claim representative whose activities are called into question, rather than one response by an insurer to a complaint.

Finally, the requirement that insurers provide a "complete written response" should exempt documents that are subject to the attorney-client and attorney work product doctrines.

8. **Section 5.3.** Reducing the requirement to reply to pertinent communications from a claimant from 15 to 10 working days is unduly burdensome. Further, this proposed rule does not make clear whether the time requirement for the response is based on the date the communication is made or the date it is received.

9. **Section 5.4.** Again, the proposed reduction of time for compliance from 15 to 10 working days is unduly burdensome.

10. **Section 6.1.** This proposed section provides that an insurer may not "unreasonably delay" resolution by seeking information not "reasonably required." The terms "unreasonable delay" and "reasonably required" are ambiguous and, thus, troubling.

11. **Section 6.2.** The language proposed by this section includes the requirement that investigations be commenced in 10 working days and that within 10 working days of completion of the investigation, the claim must be denied in writing or a written offer made. The concern here is what is *not* overtly stated: does this rule, taken together with proposed Section 6.3, establish some mandatory time period within which the investigation must be completed? If so, this is a concern because claims handling is often – and necessarily – a fluid process that changes

depending on investigative findings. The determination of what items, statements, and forms may be required may be controlled by such investigative findings. If the rule does not impose such requirement, then perhaps this should be clarified.

Additionally, Section 6.2 appears to use the terms "claimant" and "first party claimant" interchangeably and, by definition, those terms are not the same. Again, this creates ambiguity as to whether these particular rules, starting with Rule 6.1, apply to first party claimants, third party claimants, or both. Each rule should be expressly clear as to which claims, first or third party, it applies.

12. Section 6.3. The WVIF has concerns with Section 6.3 similar to those set forth with respect to Section 6.2 above. Importantly, though, the Section reference to the "completion" of an investigation is vague and ambiguous. The proposed rule does not contemplate investigations which continue and are on-going or situations where bodily injury claims result in on-going medical treatment and pending medical bills, questions or disputes involving liability or coverage.

13. Section 6.4. This rule requires that offers to third party claimants must be calculated in the same manner that would be used if the claim were made under first party coverage by an insured. This requirement completely ignores the fact that insurers owe different legal duties to first party claimants and third party claimants, a fatal flaw in this proposed language.

The duties owed by an insurer to a first party insured flow directly from the insurance contract and are governed by the language of the contract. Indeed, some member companies have policies permitting benefits to be calculated in a specific manner for first party claimants, and in a different manner for third party claimants (i.e., diminished value claims allowed under caselaw for third party claimants are prohibited under caselaw for first party insureds; replacement cost coverage for first party insureds versus actual cash value for third party claimants).

The duties owed to a third party are determined by common law and can change based upon the acts of our courts and the Legislature. In some limited instances, the language of the contract that applies to first parties requires a different manner of calculating damages and offers than the manner required by common law for calculation of third party damages and offers. The proposed rule runs afoul of this important distinction: each claimant is owed a duty, and the duties are not necessarily always the same; thus, a "one-size-fits-all" approach will not work.

Moreover, the proposed language requiring insurers to advise a claimant when a claim presented is greater than policy limits is potentially violative of privacy laws in that this proposed rule would require an insurer to provide a third party with private financial information of its policyholder without the policyholder's authorization to do so.

Finally, the rule should contemplate those situations where there is no dispute as to liability, coverage *and damages.* Damages are not currently included in the proposed language, but the WVIF believes that it should be.

14. Section 6.5. This rule sets out the information that will be considered by the Commissioner in evaluating settlement offers to determine if they are unreasonably low. Senate Bill 418 provides that disputes regarding liability or settlement values do not constitute "bad faith".

This proposed Rule also requires the disclosure of procedures used by the insurer to determine the dollar amount of property damage. Insurers use many claims handling tools to assist them in evaluating claims. The proposed Rule 6.5 requires the disclosure of confidential and proprietary claims handling tools and information to the Commissioner, and perhaps, in turn, to the claimant and claimant's counsel.

Finally, proposed Subsection (d) of the proposed rule, which requires the consideration of the "extent to which the insurer considered the advice of its counsel regarding the likelihood of recovery". This proposed language improperly infringes upon the attorney-client privilege.

The WVIF believes this is addressed by Senate 418 and is not necessary.

15. Stricken Section 6.4. This Section, which has been inexplicably stricken from the rule, permitted companies to make oral denials over the phone with appropriate notations in the file. Companies routinely do this. One company provided the routine example of an insured's calling to inquire about whether expenses associated with Roto-Rooter unclogging a drain were covered. Under the proposed rule, that insurer would be required to send a formal written denial, which would incorporate establishing a claims file and the resulting administrative cost and unnecessary claim's history for that insured. Requiring such companies to do so in writing when insureds call to determine the applicability of coverage would be unduly burdensome on these companies and, indeed, nonsensical.

The WVIF urges the Commissioner to reinstate this section and clarify whether answering a question about coverage is a denial. Further, the language is not clear whether a claim that falls within the amount of a deductible constitutes a denial.

16. Section 6.7. The striking of the phrase "first party" indicates that the proposed rule may apply to all claimants, not just first party claimants. This section also should be clarified to ensure that this rule does not apply to pending litigation.

Subject to the stated proviso, this section also relieves an insurer from the requirements of this subsection where there is "a reasonable basis . . . that such claimant has fraudulently caused the loss." The Commissioner proposes to delete the phrase "or contributed to", which is an unnecessary amendment and should remain. If, in fact, an insured fraudulently contributed to the loss, then the same result should occur: insurers should be given relief from the requirement that they provide notice of necessary delays in investigating suspected fraudulent claims.

Additionally, by striking the requirement that insurers be provided with proofs of loss eliminates the ability of insures to rely on that proof of loss to document when it received notice of the claim. Absent a proof of loss, a claimant can allege that he made a claim at any time with documentary support, thereby prejudicing insurers. NAIC model language uses proofs of loss to trigger actions, and the WVIF urges the Commissioner to retain its use.

Finally, the use of the term "delay" in Section 6.7 in addressing the notification requirements is prejudicial in that it suggests that insurers intentionally delay the processing of the claim when, in fact, the investigation may merely take longer then 30 days to adequately complete.

17. Section 6.10. Entitled "Disclaiming coverage", this proposed rule appears to confuse "disclaiming coverage" with "disclaiming liability". Despite the title of this section, it requires an insurer to inform a claimant in writing as soon as it is determined that there is no policy in force or that it is disclaiming *liability* because of a breach of policy provisions by the policyholder. While the last sentence addresses coverage disclaimers, the interchangeable use of "disclaiming coverage" and "disclaiming liability" is inaccurate and very confusing. This should be clarified.

18. Section 6.12a. Section 6.12a states that insurers are responsible for the "accuracy" of data used to establish the value of insurance claims, and are prohibited from using data which cannot be "supported as accurate". Insurers and third party database providers take reasonable and extensive measures to make sure their data is as accurate as possible. This rule imposes, however, an ambiguous standard that would make it impossible for an insurer to be sure they have achieved compliance. Any error in the database, no matter how small or immaterial, could result in a finding of "inaccuracy" that violates the rule. Insurers do not object to being held accountable for the claim databases they use so long as that

accountability is based upon a reasonable, achievable standard. The proposed rule already requires an insurer to consider any credible evidence presented by the claimant to support the value of the claim. At a minimum, the Commissioner should apply a similar standard of reasonableness that considers the extent and quality of an insurer's actions taken to assure the accuracy of the database it uses to establish the value of claims.

19. Section 6.17. This proposed rule relates to compensation of employees or agents. There is some concern that this language would unintentionally prohibit company bonuses, profit-sharing plans, and stock. The WVIF suspects that the Commissioner intended only to prevent the compensation of employees, agents or contracts based upon the intentional, improper, or wrongful denial of claims and respectfully recommend the clarification of this language.

20. Section 6.20. A close reading of this rule seems to indicate that where a claim involves a loss of profits or income, it may be acceptable for an insurer to require documents revealing the claimant's income. As written, this is not clear. Otherwise, based upon potential interpretations, this rule could considerably hamper the evaluation of loss of income and earning capacity claims. Indeed, the income of a claimant is pertinent in determining the true property loss, and failure to use this to support a claim would increase the potential for fraud. This rule should be clarified to address this issue.

Additionally, existing policies typically include language that outlines an insured's duties following a loss and requires insureds to show, among other things, records, such as tax returns and bank records. This proposed language would conflict with this existing policy language. As an alternative, the Commissioner could consider the following language that would address these issues: "An insurer may require a claimant, as part of the investigation of a claim, to produce his or her federal income tax returns or other financials documents that may be pertinent as stipulated in the policy."

Finally, the reference to "fire loss" is overly limiting and could be construed in such a way that it would be inconsistent with existing policy language previously approved by the Insurance Commissioner.

20. Section 6.22. The requirement in this proposed rule that an insurer provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation is unduly burdensome.

21. Section 6.24. The requirement that the insurer provide information for claims denial notices is similarly unduly burdensome.

22. **Section 8.1.** The words "affording coverage" to third parties should be stricken because insurers "afford coverage" to their insureds, not to third parties.

23. **Section 8.2.** This rule requires that a third party claimant be furnished with certain information if a denial is issued. First, the proposed standard is that an insurer shall deny a claim within 10 working days of its notice, based on a good faith belief. The term "good faith" is vague and the time frame is too short for an insurer to reach a "good faith" belief. Specifically, a good faith belief should be investigated; an investigation may reveal facts; and claim denials should be based on facts. The proposed rule, as a practical matter, would eliminate the investigation stage.

Second, the WVIF maintains its concern that the disclosure of insureds' policyholder information to a third party jeopardizes its duty to its insured to maintain the confidentiality of its insureds' private information. Moreover, the requirement that the insurer provide the policy number is not as efficient or logical as the provision of a claims number from a claims handling standpoint. The WVIF urges the amendment of the rule to reflect this change.

24. **Section 8.2b.** This rule requires written acknowledgment by the insurer of all claims and requires insurers to inform the claimant that the insured has a policy with certain coverages available. However, this appears to be "overkill" for certain claims, for instance, in a small automobile property damage claim, the claimant simply wants the check, not forms and acknowledgements. This proposed language would eliminate the efficient resolution of claims in some situations.

Additionally, this section requires the disclosure of policy limits to third party claimants and, again, the WVIF continues to maintain its concern about its insureds' privacy interests.

25. **Section 8.3.** The requirement that notice of the reservation of rights is to be given within seven working days is too short and should be extended from a practical standpoint, not only for the benefit of insureds and insurers. An insured, for example, could go on a vacation or otherwise be unable to provide the required notice within seven working days. Insurers prefer to wait to determine whether its customer, the insured, will cooperate in the resolution of the claim. This notice, if sent prematurely and consistent with this proposed rule's seven working day requirement, could harm an insurer's relationship with its customers.

26. **Section 9.1.** The WVIF respectfully urges the Commissioner to clarify that the Insurance Commissioner will provide any notice of a third party complaint and that such notice will be in writing.

The WVIF also notes that this section begins the 45-day period from the date of receipt of the notice, which is inconsistent with Rule 5.2, which begins that period from the date appearing on the notice. This is an internal inconsistency in these rules that should be addressed.

27. Section 9.2. The proposed rule relating to the determination as to the need for a hearing is triggered when "an offer should have been made" or was "unreasonable", but the newly enacted statute says that any dispute as to the value of a claim does not constitute "bad faith" and would, therefore, not trigger a right to a hearing. This proposed section is inconsistent with Senate Bill 418.

This section as written also appears to unfairly impose the duty to negotiate in good faith on only one party, the insurer.

The last sentence defines "offer" as a proposal to correct the alleged unfair claims settlement practice, implying that not only can the complainant attempt to negotiate a settlement above the value of the underlying case due to the alleged bad faith, but the Commissioner can determine whether such enhanced settlement offer was reasonable. This effectively permits the negotiation of a global settlement by the complainant to include the underlying claim plus BF damages. In conjunction with proposed Section 6.23, the complainant can offer to dismiss the administrative complaint as consideration for a higher settlement offer, thus providing a mechanism for a third party action within the provisions of the administrative remedy, separate and apart from the administrative remedy intended by Senate Bill 418. The WVIF is both concerned and perplexed by the proposed definition and urges the Commissioner to reconsider it.

28. Section 9.3b. This proposed rule creates a new legal standard of an "egregious act" not contemplated by the statute. Specifically, the proposed language would permit restitution regardless of whether the act occurred within a general business practice. The UTPA only provides for investigation and hearing to determine if the person has committed an unfair claims settlement practice with such frequency as to constitute a general business practice. The UTPA allows administrative action for findings of an unfair claim settlement practice, which is a general business practice or an intentional act, not on the sole basis of an "egregious act". This should be remedied before the Final Rules are adopted.

29. Section 10. The term "claims agents" is undefined, and the inconsistent and apparently interchangeable use of that term in Rules 10.1, 10.2, and 10.3 and the term "insurance adjusters" in Rule 10.3. is very confusing and should be clarified.

Also, some agents may utilize their draft authority to settle claims directly, which this proposed Rule does not contemplate and, in fact, appears to prohibit. There also are those claims adjusters and personnel who handle claims from a central office located out-of-state by

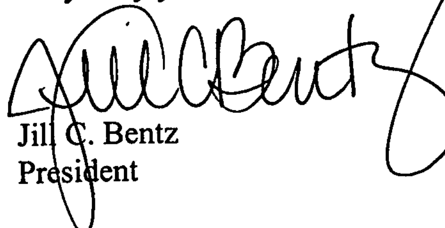
phone and facsimile and who do not physically enter the state of West Virginia (and who are currently exempt for licensing requirements for a WV Adjusters' License), which also is not contemplated by the proposed rule.

The WVIF believes the addition of this section will add significantly to the compliance burden and costs to the industry without providing any associated benefits to companies' insureds or third party claimants. Interestingly, this section requires that insurers provide claims personnel with "clear written instructions" to "effect proper compliance with this rule." In essence, this proposed section imposes a burden upon the insurer to prepare a written document to explain the written rules when, in fact, written manuals and training programs are out of date by the time they are received. In fact, few, if any, insurers still use a traditional paper training manual. Yet, an insurer's inability to update and publish such items and verify the inclusion of every court decision and administrative ruling will automatically render an insurer out of compliance and in violation of the rule, even when such decisions and rulings have no material effect on the settling of claims or resolution of disputes. Moreover, the specific provisions of the training and certification system apparently contemplated by the proposed language offer unlimited opportunities for personal injury lawyers to harass companies, resulting in the attendant high defense costs, without regard to the merits, or lack thereof, of a specific third party claim. We respectfully request the new language in this section be stricken in its entirety and that the language contained in the existing rule be preserved.

Finally, and importantly, these proposed rules should include a provision whereby the records, claims, and any other information falling within the purview of these Rules is confidential and not subject to the Freedom of Information Act ("FOIA"). The documents generated by the Office of the Insurance Commissioner or produced to the Office of the Insurance Commissioner in connection with investigations of claims should not be "public records" subject to FOIA requests merely because they are delivered to the Office of the Insurance Commissioner.

Thank you for the opportunity to provide these comments. Naturally, if you have any questions or need additional information of any kind, we are available to meet or discuss these comments. Please do not hesitate to contact me.

Very truly yours,



Jill C. Bentz
President

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #18

SPILMAN THOMAS & BATTLE, PLLC

ATTORNEYS AT LAW

Direct Dial: 304.340.3880
E-Mail: jbentz@spilmanlaw.com

July 25, 2005

RECEIVED
JUL 2 5 2005
WVIC LEGAL DIVISION

BY HAND-DELIVERY
Victor A. Mullins
Associate Counsel
Legal Division
West Virginia Insurance Commission
1124 Smith Street
Charleston, West Virginia 25301

RE: American International Group
Comments – Proposed Administrative Rules
Title 114, Series 14

Dear Mr. Mullins:

American International Group ("AIG") respectfully requests consideration of the following comments to the proposed amendments to 114 CSR 14, relating to Unfair Trade Practices.

1. **Section 2.14.** The definition proposed for "egregious act" includes conduct that is "clearly irresponsible", which is a lower legal standard and contemplates unintentional, negligent acts. Indeed, "clearly irresponsible" conduct is simple negligence and, therefore, implies a standard that is lower than "gross negligence." It is not fraudulent, malicious or reckless conduct, which is heightened conduct that exposes the actor to punitive damages. The inclusion of "clearly irresponsible" conduct in the first sentence of the definition is inconsistent with the statement in the second sentence that "simple negligence" is not an egregious act. The term "clearly irresponsible" should be stricken from this definition.

Similarly, the term "gross negligence" is not egregious but could be implied as such under this proposed Rule.

Finally, neither the definitions nor any other section of the rule indicates who will make such findings, at what stage such findings will be made, and which party will bear the burden of proof. In light of the fact that the definition of "egregious act" contemplates fraudulent acts, the appropriate standard of proof is "clear and convincing."

2. **Section 4.1.** The proposed Rule deletes language that is National Association of Insurance Commissioners ("NAIC") model language, which seems inconsistent with recent efforts to bring West Virginia's insurance market into the mainstream as well as previous, unrelated efforts to adopt NAIC model language into West Virginia's statutory framework.

Additionally, the absence of the qualifier "pertinent" from the first sentence, although retained in the sub-heading, could introduce an impracticable and excessive disclosure standard.

3. **Section 4.4.** This proposed Rule essentially provides that there can never be a "late claim" unless the policy contains a specific deadline for making a claim. This raises concerns about late notice and the resulting prejudice to the insurer due to untimely filing of claims. It also raises the concern that this portion of the Rule could conceivably be interpreted to supplant applicable statutes of limitations or other statutorily-prescribed time frames.

4. **Section 4.5.** Proposed Section 4.5 provides that "[a]ny payment, settlement or offer of settlement that, without explanation, does not include all amounts which should be included according to the claim filed . . . shall be deemed to be a communication that misrepresents a pertinent policy provisions." AIG is concerned that liability under the Unfair Trade Practices Act ("UTPA") could attach for simple, isolated calculation errors that do not materially affect the payment or value of the claim, such as an incorrect calculation of claim interest.

5. **Section 5.1.** This is the first of many proposed rules in this Series that reduces time requirements from 15 working days to 10 working days. Decreasing the time frame for acknowledgement of notices of claims from 15 to 10 working days appears to serve no legitimate purpose, particularly where violations of this time frame are considered to be acts of "bad faith."

Where a policy provides that an agent cannot receive a claim, then this section should make clear that there is no duty on the agent to send a written communication to that effect. Sections 5.1 and 6.2 appear to be in conflict on this point. AIG seeks confirmation that the agent does not need to send such written communication in this situation.

6. **Section 5.2.** This proposed Section requires responses within 10 working days from the date appearing on the inquiry, rather than 15 working days from receipt of the inquiry from the Office of the Insurance Commissioner. AIG believes that the change from "receipt of inquiry" to the "date appearing on the inquiry" is completely unworkable and creates an impossible burden on complaint handling personnel.

Even under optimal mail and internal routing time frames, the standard as written would leave little or no time to adequately research and address the issue(s) raised in the

complaint. AIG does not want to be held liable purely as a result of an unrealistic complaint-handling time frame. This amendment easily can be cured by changing the language to "receipt of the inquiry", which is the trigger for other actions contained within this very series of Rules.

7. **Section 5.3.** Again, this section, relating to replies to other pertinent communications, should insert language that the time frame for such a reply will be triggered "upon receipt".

8. **Section 6.2.** See Comments to proposed Section 5.1 above.

9. **Section 6.4.** This rule requires that offers to third party claimants must be calculated in the same manner that would be used if the claim were made under first party coverage by an insured. This requirement completely ignores the fact that insurers owe different legal duties to first party claimants and third party claimants.

The duties owed by an insurer to a first party insured flow directly from the insurance contract and are governed by the language of the contract. Indeed, some member companies have policies permitting benefits to be calculated in a specific manner for first party claimants (i.e., diminished value claims allowed under caselaw for third party claimants are prohibited under caselaw for first party insureds; replacement cost coverage for first party insureds versus actual cash value for third party claimants).

The duties owed to a third party are determined by common law and can change based upon the acts of our courts and the Legislature. In some limited instances, the language of the contract that applies to first parties requires a different manner of calculating damages and/or offers than the manner required by common law for calculation of third party damages and/or offers. The rule runs afoul of this important distinction: each claimant is owed a duty, and the duties are not necessarily always the same, thus a "one-size-fits-all" approach will not work.

Moreover, the proposed language requiring insurers to advise a claimant when a claim presented is greater than policy limits is potentially violative of privacy laws in that this proposed Rule would require an insurer to provide a third party with private financial information of its policyholder without the policyholder's authorization to do so.

10. **Section 6.5.** This rule sets out the information that will be considered by the Commissioner in evaluating settlement offers to determine if they are unreasonably low. Senate Bill 418 provides that disputes regarding liability and/or settlement values do not constitute "bad faith". Due to this inconsistency, AIG believes this section should be stricken.

Proposed Subsection (d) of the proposed Rule, which requires the consideration of the "extent to which the insurer considered the advice of its counsel regarding the likelihood of recovery", improperly infringes upon the attorney - client privilege.

And, the inclusion of proposed Subsection (f) is also improper. This factor – "the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matters" – should not be relevant to the finding of "bad faith." Indeed, predicting a jury somewhat analogous to predicting weather. The inappropriateness of including this as a factor is underscored by the predominance of jury bias against insurers. This is not a valid factor and should be stricken.

11. Section 6.7. Striking the requirement that insurers be provided with proofs of loss eliminates the ability of insures to rely on that proof of loss to document when it received notice of the claim. Absent a proof of loss, a claimant can allege that he made a claim at any time without documentary support, thereby prejudicing insurers. "Proof of loss" should be the trigger, not the "notice of claim", particularly since a notice of claim can take any form, whereas a proof of loss provides documentation of the loss and constitutes more formal, defined notice.

Additionally, it is not clear whether the proposed Section applies to third party claimants.

12. Section 8.2. This proposed Section addresses the duties of an insurer upon receipt of notice of a claim and requires that a third party claimant be furnished with certain information if a denial is issued. The proposed standard is that an insurer shall deny a claim "within 10 working days" based upon a "good faith belief". Again, this section should insert "upon receipt of notice" so that the time period provided will be triggered following *receipt*.

Second, the term "good faith" is vague and the time frame too short for an insurer to reach a "good faith" belief. Specifically, a good faith belief should be investigated; an investigation may reveal facts; and claim denials should be based on facts. This rule as proposed and as a practical matter would eliminate the investigation stage.

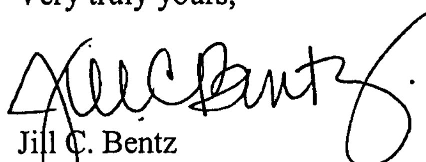
13. Section 9.3b. Proposed Section 9.3b creates a new legal standard of an "egregious act" not contemplated by the statute. Specifically, the proposed language would permit restitution regardless of whether the act occurred within a general business practice. The UTPA only provides for investigation and hearing to determine if the person has committed an unfair claims settlement practice with such frequency as to constitute a general business practice. The UTPA allows administrative action for findings of an unfair claim settlement practice, which is a general business practice or an intentional act, not on the sole basis of an "egregious act". This should be remedied before the Final Rules are adopted.

14. **Section 10.** AIG believes the addition of this section will add significantly to the compliance burden and costs to the industry without providing any associated benefits to insureds or third party claimants. Furthermore, AIG believes that these provisions offer unlimited opportunities for personal injury lawyers to harass companies, resulting in the attendant high defense costs, without regard to the merits, or lack thereof, of a specific third party claim. AIG respectfully requests that proposed Section 10 be stricken in its entirety and that the language contained in the existing rule be preserved.

Finally, and importantly, these proposed Rules should include a provision whereby the records, claims, and any other information falling within the purview of these Rules is confidential and not subject to the Freedom of Information Act ("FOIA"). The documents generated by the Office of the Insurance Commissioner or produced to the Office of the Insurance Commissioner in connection with investigation of claims should not be "public records" subject to FOIA requests merely because they are delivered to the Office.

Thank you for the opportunity to provide these comments. Naturally, if you have any questions or need additional information of any kind, please let me know.

Very truly yours,



Jill C. Bentz
Counsel for American International Group

cc: The Honorable Jane L. Cline
Mary Jane Pickens

TITLE 114, SERIES 14
UNFAIR TRADE PRACTICES

COMMENT #19

ALLSTATE INSURANCE COMPANY
12150 East Monument Drive
Fairfax, VA 22033
Telephone (703) 218-0106
Fax (703) 218-0291

RECEIVED
JUL 25 2005
WVIC LEGAL DIVISION

July 25, 2005

Victor A. Mullins
West Virginia Insurance Commission
1124 Smith Street
Charleston, WV 25301

VIA HAND-DELIVERY

Re:Comments—Proposed Administrative Rules,
Title 114, Series 14

Dear Mr.Mullins:

Allstate Insurance Company wishes to express its serious concern about the potential impact of the above-captioned proposed rules. We will not repeat here the extensive comments submitted by the West Virginia Insurance Federation and the Property Casualty Insurers Association, except to say that Allstate participated fully in the development of the WVIF and PCI comments, and adopts them as our own.

In addition to the WVIF and PCI comments, we have a general concern about how the proposed rules appear to reverse the considerable progress made by the General Assembly the last two years in moving West Virginia back into the mainstream of the country's insurance regulatory environment. Important legislative changes have eliminated a number of laws that were clearly out-of-step with the rest of the country. Those overturned and amended laws were a major reason why insurers, and the business community, generally, found West Virginia to be a difficult place to do business. The proposed rules are a step backward. For example, reducing the already restrictive 15 day response deadlines to only 10 days will create a significant and unwarranted compliance burden that is imposed nowhere else. In addition, the rules' requirement that third parties be afforded the same duties and obligations as policyholders is a major and unjustified departure from commonly accepted principles of contract law.

We urge you to reconsider the necessity and scope of these proposed rules, and carefully consider the detailed comments of the WVIF and PCI.

Thank you for your consideration.

Sincerely yours,

Jeffrey W. Williams
Regional Counsel

cc: Jane Cline, Commissioner

114CSR14

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 14
UNFAIR TRADE PRACTICES

Section.

114-14-1. General.

114-14-2. Definitions.

114-14-3. File and Record Documentation.

114-14-4. ~~Unfair Or Deceptive Acts Or Practices~~ Representation of Policy Provisions and Benefits.

114-14-5. Standards for the Acknowledgment of Pertinent Communications.

114-14-6. Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to All Insurers.

114-14-7. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

114-14-8. Training and Certification.

114-14-9. Separability.

114-14-10. Penalty for Violation of Any Provision of this Regulation.

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OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

114CSR14

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 14
UNFAIR TRADE PRACTICES

§114-14-1. General.

1.1. Scope.

a. The purpose of this ~~regulation~~ rule is to define certain practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and to establish certain minimum standards and methods of settlements of both first party and third party claims.

b. This ~~regulation~~ rule does not prohibit the use of additional methods above the minimum which are not in violation of this regulation or any other West Virginia statute or regulation.

c. ~~This regulation defines certain practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and establishes certain minimum standards for the settlement of claims.~~ This ~~regulation~~ rule applies to all persons and to all insurance policies and insurance contracts except Workers' Compensation Insurance.

d. This ~~regulation~~ rule is not exclusive, and other acts, not herein specified, may also constitute unfair claims settlement practices.

e. Nothing in this rule creates or recognizes, either explicitly or impliedly, any new or different cause of action not otherwise recognized by law.

1.2. Authority. -- W. Va. Code §§33-11-4a(h) and §33-2-10.

1.3. Filing Date. -- ~~April 3, 2003.~~

1.4. Effective Date. – ~~April 3, 2003.~~

§114-14-2. Definitions.

For the purposes of this regulation, the following definitions shall apply:

2.1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

2.2. "Claimant" means either a first party claimant, a third party claimant, or both~~, and includes such claimant's designated legal representative, a designated member of the claimant's immediate family, or any other person named by the insured who may legally act on his or her behalf and who so acts without compensation of any kind~~.

2.3. "First Party Claimant" or "Insured" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract for which premiums were paid by the claimant or on the claimant's behalf.

2.4. "Person" includes any individual, company, insurer, association, organization, society, reciprocal, business trust, corporation or any other legal entity, including agents, adjusters and brokers.

2.5. "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract covering risks resident, located or to be performed in this state.

2.6. "Investigation" means all activities of an insurer or agent directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

2.7. "Notification of Claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agents, by a claimant, which reasonably apprises the insurer or agent of the existence of an occurrence which might give rise to liability under a policy or contract of insurance.

2.8. "Third Party Claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer for which premiums were not paid by the claimant or on his or her behalf.

2.9. "Settlement of Claims" means all activities of the insurer or its agent which are related directly or indirectly to the determination of the extent of compensation that is due under coverage afforded by the insurance policy or insurance contract. This shall include, but not be limited to, the requiring or preparing of repair estimates.

2.10. "Insurance Policy" or "Insurance Contract" means the contract effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers issued under the terms of the policy or contract.

2.11. "Claim" means any communication by a claimant to an insurer or its agent which reasonably apprises the insurer or agent of an occurrence which might give rise to liability under a policy or contract of insurance.

2.12. "Commissioner" means the West Virginia Insurance Commissioner.

2.13. "Licensee" means any person that holds a license or Certificate of Authority from the commissioner, or any other entity for whom the commissioner's consent is required before transacting business in the State of West Virginia or with residents of West Virginia.

2.14. "Egregious Act" means conduct that is fraudulent or malicious and reckless, whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice. An act, or failure to act, that is due to negligence, lack of judgment, incompetence, or bureaucratic confusion, is not an egregious act.

§114-14-3. File And Record Documentation.

3.1. File and record documentation. -- The insurer's claim files shall be subject to examination by the commissioner or by his or her duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. All communications and transactions emanating from or received by the insurer shall be dated by the insurer. A notation of the substance and date of all oral communications shall be contained in the clam file. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.

§114-14-4. ~~Unfair Or Deceptive Acts Or Practices~~ Representation of Policy Provisions and Benefits.

4.1. Failure to disclose pertinent policy provisions. -- No person shall knowingly fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

4.2. Concealment of pertinent policy provisions. -- No person ~~shall~~ may knowingly conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

4.3. Coercive statements. -- No person ~~shall~~ may make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of the provisions of a statute of limitation or a policy or contract time limit.

4.4. Time limit for notification of claim. -- Except where a time limit is specified in the policy or set by statute or rule, no insurer may require a first party claimant to give notification of a claim or proof of claim within a specified time.

~~4.4.~~ 4.5. Releases.

a. No person ~~shall~~ may request a first party claimant to sign a release ~~which~~ that extends beyond the subject matter which gave rise to the claim payment.

b. No insurer ~~shall~~ may issue any check or draft, in partial settlement of a loss or claim under a specific coverage, ~~which~~ that contains language which releases the insurer or its insured from its total liability.

§114-14-5. Standards For The Acknowledgment Of Pertinent Communications.

5.1. Acknowledgment of notices of claims. -- Every insurer, upon receiving notification of a claim shall, within fifteen (15) working days, acknowledge the receipt of such notice unless full payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

5.2. Answer of inquiries from Insurance ~~department~~ Commissioner. -- Every insurer, producer or other licensee, upon receipt of any inquiry other than a notice of third party administrative complaint from the Insurance ~~Department respecting a claim~~ Commissioner shall, within fifteen (15) working days of ~~receipt of such inquiry~~ the date appearing on the inquiry, furnish the ~~department~~ Commissioner with a complete written response to the inquiry. A "complete written response" addresses all issues raised by the complainant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or his or her staff conducting a scheduled examination on the insurer's premises.

5.3. Replies to other pertinent communications. -- A reply shall be made within fifteen (15) working days of receipt by the insurer to all other pertinent communications from a claimant which reasonably suggest that a response is expected.

5.4. Provisions of assistance to first party claimants. -- Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this ~~paragraph~~ subsection within fifteen (15) working days of notification of a claim shall constitute compliance with subsection 5.1 of this section.

§114-14-6. Standards For Prompt Investigations And Fair And Equitable Settlements Applicable To All Insurers.

6.1. Investigation of claims. -- Every insurer shall promptly conduct and diligently pursue a thorough, fair and objective investigation and may not unreasonably delay resolution by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute.

6.2. Establishment of investigatory procedures. --

(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within fifteen (15) working days of receipt of notice of claim.

(b) Every insurer shall provide to every first party claimant, or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of ~~the~~ such claimant, within fifteen (15) working days of receiving notice of the claim.

(c) A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent ~~notifies~~ promptly provides written notification to the person filing the claim that the agent is not authorized to receive notices of claim.

6.3. Duty after investigation. -- Within ten (10) working days of the completion of its investigation, the insurer shall deny the claim in writing or make a written offer, subject to policy limits.

~~6.2.~~ 6.4. Offers of settlement. --

(a) In any case where there is no dispute as to coverage ~~or~~ and liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

(b) No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any evidence offered regarding the

following factors in determining whether or not a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

4. The extent to which the insurer considered the opinions of independent experts;

5. The procedures used by the insurer in determining the dollar amount of property damage;

6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and

7. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is or is not below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

~~6.3.~~ 6.5. Denial of claims. -- No insurer ~~shall~~ may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing or as otherwise provided in subsection ~~6.4~~ 6.6 of these rules.

~~6.4.~~ 6.6. Records of denial of claims. -- If a denial of a claim is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

~~6.5.~~ 6.7. Notice of necessary delay in investigating claims. -- If the insurer needs more ~~time~~ than thirty (30) calendar days from the date that a proof of loss from a first party claimant or notice of claim from a third party claimant is received to determine whether a ~~first party~~ claim should be accepted or denied, it shall so notify the ~~first party~~ claimant in writing within fifteen (15) working days after ~~receipt of the proofs of loss~~ the thirty-day period expires. If the investigation remains incomplete, the insurer shall ~~send to such claimant within thirty (30)~~

~~calendar days from the date of the initial~~ provide written notification ~~and~~ of the delay to the claimant every ~~thirty (30)~~ forty-five (45) calendar days thereafter~~,~~ ~~a letter setting~~ until the investigation is complete. All such notifications must set forth the reason(s) additional time is needed for investigation. Where there is a reasonable basis supported by specific information available for review by the commissioner that such claimant has fraudulently caused or contributed to the loss ~~by arson~~, the insurer is relieved from the requirements of this subsection: *Provided*, That the claimant shall be notified of the acceptance or denial of the claim within a reasonable time allowing for full investigation ~~after receipt by the insurer of a properly executed proof of loss~~. Nothing contained in this subsection shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

~~6.6.~~ 6.8. Liability of others. -- Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

~~6.7.~~ 6.9. Denial of claims for failure to exhibit property. -- No insurer ~~shall~~ may deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit said property.

~~6.8.~~ 6.10. Separation of claims. -- In any case where there is no dispute as to one (1) or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

~~6.9.~~ 6.11. Time for payment of claims. -- Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than fifteen (15) working days from the receipt of such agreement by the insurer or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

~~6.10.~~ 6.12. Notice of applicable time limitations. -- No person shall negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant's rights may be affected by a statute of limitations or a policy or contract time limit. Such notice shall be given to first party claimants not less than thirty (30) days, and to third party claimants not less than sixty (60) days, before the date on which such time limit may expire.

~~6.11.~~ 6.13. Avoidance of payment. -- Where liability and damages are reasonably clear, no person ~~shall~~ may recommend that third party claimants make claim under their own policies solely to avoid paying claims under an insurer's insurance policy or insurance contract.

~~6.12.~~ 6.14. Unreasonable travel. -- No person ~~shall~~ may require a claimant to travel unreasonably either to inspect a replacement motor vehicle or to obtain a repair estimate ~~or to have the motor vehicle repaired at a specific repair shop~~.

6.15. Compensation based on claim denials. -- No insurer may offer incentives or compensate its employees, agents or contractors based on savings to the insurer as a result of improperly denying the payment of claims.

6.16. Claim proceeds used to pay premiums of another policy. -- No insurer may deduct from a claim payment made under one policy premiums owed by the insured on another policy unless the insured consents.

6.17. Truth detection devices. -- No insurer may request or require a claimant to submit to a polygraph examination or other truth detection device unless authorized under the applicable insurance contract and state law. No insurer may utilize a truth detection device in connection with the settlement of a claim unless the claimant gives written consent prior to the use of the device.

6.18. Required information for claim denial notices. -- Any notice rejecting any element of a claim shall contain the identity and the claims processing address of the insurer and the claim number. The notice must state that the claimant has the option of contacting the commissioner. The notice must provide the commissioner's mailing address, telephone number and web site address.

§114-14-7. Standards For Prompt, Fair And Equitable Settlements Applicable To Automobile Insurance.

7.1. Applicability. -- This section is applicable to claims arising under motor vehicle collision and comprehensive coverage. The provisions of section 6 of these rules shall continue to be applicable to these claims except to the extent that such provisions are inconsistent with the specific provisions of this section.

7.2. Definition of terms. -- The following shall govern the construction of the terms used in this section:

a. "Agreed price" shall mean the amount agreed to by the insurer and the insured, or their representatives, as to the reasonable cost to repair damages to the motor vehicle resulting from the loss, without considering any deductible or other deductions;

b. "Designated representative" shall mean a person designated by the insured to

represent him or her in negotiations with the insurer in an attempt to settle the claim. Such designated representative may be a member of the insured's immediate family or any other person named by the insured who may legally act on his or her behalf and who so acts without compensation of any kind;

c. "Motor vehicle" shall have the meaning ascribed in subsection (b), section one, article one, chapter seventeen-a of the Code of West Virginia of 1931, as amended;

d. "Official used car guide" means a valuation source that has been approved by the commissioner for setting the minimum value of a motor vehicle which is the subject of a total loss claim. In order to be approved by the commissioner as an official used car guide, the valuation source must meet the following criteria:

1. All valuation sources must:

A. Produce statistically valid fair market values based on current data available primarily from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters, such as time and area, to assure statistical validity;

B. Produce values for at least eighty-five percent (85%) of all makes and models of private passenger automobiles for the last fifteen (15) model years and include all major options. A sufficient number of vehicles shall be used for each year, make and model to represent a cross-section sufficient to determine fair market values;

C. Produce for examination by the commissioner, at the time the request for approval is made or as soon thereafter as practicable, the source of the data in a manner that can be verified by the commissioner;

D. Make available for examination by the commissioner, at the time the request for approval is made or as soon thereafter as practicable, any contracts or agreements between the valuation source and insurers, which the valuation source may assert is a trade secret pursuant to W. Va. Code §47-22-1(d); and

E. Produce for examination any other information determined by the commissioner to be helpful or necessary in determining the statistical validity of the values produced by the valuation source, or otherwise bearing on the integrity of the valuation source, including the existence of and resolution of consumer complaints based upon total loss valuations performed by the source. If the information meets the definition of trade secret pursuant to W. Va. Code §47-22-1(d), then the valuation source may make available for

examination by the commissioner, without filing the same, any information requested pursuant to this subparagraph. If the information meets the definition of trade secret pursuant to W. Va. Code §47-22-1(d) and, after having been made available for examination by the commissioner, the commissioner determines that the information pertains to the existence of or resolution of consumer complaints, the valuation source shall propose a reasonable method for protection of the information.

2. A valuation source that is other than a valuation manual, including a computerized database, must meet the criteria set forth in subparagraphs A, B, C, D and E of paragraph one of this subdivision, and in addition must:

A. Give primary consideration to the values of vehicles in the local market area but if necessary to obtain a reasonable cross-section of the market, may consider vehicles in the next closest area;

B. Rely upon values of vehicles that are currently available or were available within ninety days from the date of loss for all vehicles and apply appropriate standards of comparability;

C. Rely upon values derived primarily from verifiable data or inventory from licensed dealers which have minimum sales of one hundred motor vehicles per year in the local market area, for vehicles of five model years or less of age;

D. Monitor the average retail price of private passenger automobiles when there is insufficient data or inventory from licensed dealers to ensure statistically valid market area values; and

E. Clearly indicate and describe the condition at which the vehicle is being valued, if the valuation source uses several price ranges for the same model vehicle depending on the condition of the vehicle. Documentation of the condition of the insured vehicle must be made a part of the written valuation. Deductions made for the condition of the insured vehicle must be reasonably based on a physical attribute that has the effect of decreasing the vehicle's value.

e. "Substantially similar vehicle" shall mean a motor vehicle of the same make, model, year and substantially the same condition, including all major options of the insured vehicle. Mileage must not exceed that of the insured vehicle by more than 4,000 miles unless mutually acceptable to both the insurer and the insured.

7.3. Adjustment of partial losses. -- The following subdivisions shall govern the conduct

of insurers in the adjustment of partial losses:

a. Insurers shall include the insured's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense;

b. If an insurer prepares an estimate of the cost of the motor vehicle repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the insured and may furnish to the insured the names of one or more conveniently located repair shops that will perform the repairs for the amount tendered in settlement of the claim;

c. If the insurer intends to exercise its rights to inspect damages prior to repair, it shall have seven (7) working days from the date of receipt of notice of loss to inspect the insured's damaged motor vehicle at a place and time reasonably convenient to the insured. In addition, negotiations shall commence and a good faith offer of settlement shall be made within the aforesaid seven (7) day period;

d. If the insured's motor vehicle is repaired at a repair shop of the insurer's choice, for a sum estimated by the insurer as the reasonable cost to repair the vehicle, the insurer shall, at no additional cost to the claimant and within a reasonable period of time, cause the damaged vehicle to be restored to the condition it was in prior to the loss if the repair shop it recommended does not so repair the damaged motor vehicle;

e. Deductions for betterment and/or depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and/or depreciation shall be limited to an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part. Calculations for betterment, depreciation and normal useful life must be included in the insurer's claim file;

f. Deductions for previous damage or prior condition of the motor vehicle must be measurable, discernible, itemized and specified as to dollar amount, and such deductions must be detailed in the claim file;

g. The insurer must mail or hand deliver to the insured or his or her designated representative its proof of loss or payment within ten (10) working days after the insured has accepted the insurer's offer;

h. If the insurer does not perform its own physical inspection, it is nevertheless bound by all the applicable requirements of this regulation.

7.4. Adjustment of total losses. -- The following subdivisions shall govern the conduct of insurers in the adjustment of total losses:

a. If the insurer elects to make a cash settlement:

1. It must use the most recent version of an "Official Used Car Guide" approved by the commissioner and uniformly and regularly used by the company, as a guide for setting the minimum value of the motor vehicle which is the subject of the claim. Any deviation downward from the guide's retail valuation must be supported by documentation that gives detailed information about the vehicle's condition, and any deductions must be measurable, discernible, itemized and specified concerning dollar amount, and they shall be appropriate in amount. This documentation must be maintained in the claim file;

2. If the retail value of the specific motor vehicle is not contained in the most recent version of an "Official Used Car Guide" approved by the commissioner and which is used uniformly and regularly by the company, the company must secure dealer quotations on the retail value of similar vehicles and base the settlement upon them. The offer must enable the insured to purchase the substantially similar vehicle for the cash settlement and any deviation from this practice must be supported by documentation giving particular information about the motor vehicle's condition. The documentation and the source of the dealer quotations must be maintained in the claim file;

3. The company shall provide a reasonable written explanation to the concerned parties when cash settlement offers, as set forth in paragraphs (1) and (2) above are made. The explanation must specify the dollar amount of the base figure and identify the actual source. Any additions or subtractions from the base dollar figure must be identified and explained; and

4. In addition to any cash settlement value agreed to by the claimant, there must be added an amount equal to five percent (5%) of such cash settlement value, as reimbursement to the claimant for the excise tax imposed by the state.

b. If the insurer elects to replace the vehicle, the replacement vehicle must be an immediately available, substantially similar vehicle that is both furnished and paid for by the insurer, subject to the deductible, if any.

c. If the insured vehicle is a private passenger automobile of the current model

year, meaning that it has not been superseded in the marketplace by an officially introduced succeeding model, the insurer shall utilize one of the following methods in the settlement of the loss, except where the method used would be detrimental to the interests of the insured as compared with utilization of the methods described in subdivisions a and b above:

1. The insurer shall pay to the insured the reasonable purchase price on the date of loss of a substantially similar vehicle, less any applicable deductible and an allowance for depreciation in accordance with an official used car guide which has been approved by the commissioner and is used regularly by the insurer; or

2. The insurer shall furnish the insured with a substantially similar replacement vehicle, and charge the insured for any applicable deductible and for depreciation in accordance with the official used car guide.

d. If the insurer, in the process of adjusting a total loss, makes a deduction for the salvage value of the insured vehicle, the insurer must furnish the insured with the name and address of a salvage dealer who will purchase the salvage for the amount deducted.

e. All applicable provisions of subsection 7.3 of this section "Adjustment of Partial Losses" also shall apply to the adjustment of total losses, except that the insurer shall be allowed an additional five (5) working days to comply with the requirements set out in subsection 7.3 of these rules. Any letter of explanation or rejection of any element of a claim shall contain the identity and claims processing address of the insurer, the insured's policy number and the claim number.

7.5. Unreasonable delay. -- If any element of a physical damage claim remains unresolved more than fifteen (15) working days from the date of receipt of proofs of loss by the insurer, the insurer shall provide the insured with a written explanation of the specific reasons for the delay in the claim settlement unless reasonable grounds exist to suspect fraud or arson. An updated letter of explanation shall be sent every thirty (30) calendar days thereafter until all elements of the claim are either honored or rejected.

7.6. Repair estimates. -- If an insurer requires that its insured obtain an estimate or estimates of vehicle damage, the reasonable charges, if any, of such estimates shall be borne by the insurer.

7.7. Notice of right to reimbursement for transportation expenses. -- In the event of the theft of the entire vehicle, it shall be the duty of the insurer at the time of notification of loss to advise the insured of his right under the policy to be reimbursed for transportation expenses. Such notification must be confirmed in writing immediately after receipt of notice of theft. All

conditions and benefits related to this coverage as stated in the policy must be contained in the notification to the insured.

§114-14-8. Training and Certification.

8.1. Communication of investigatory and claim processing standards. -- Within ninety (90) days of the effective date of this rule, every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims.

~~§114-14-8.~~ §114-14-9. Separability.

~~8.1.~~ 9.1. Partial invalidity. -- If any provision of this ~~regulation~~ rule shall be held invalid, the remainder of the ~~regulation~~ rule shall not be affected thereby.

~~§114-14-9.~~ §114-14-10. Penalty For Violation Of Any Provision Of This Regulation.

~~9.1.~~ 10.1. Penalty. -- Any person who fails to comply with any provision of this regulation shall, after notice and hearing, be found to be transacting insurance in an illegal, improper or unjust manner. The commissioner may, pursuant to ~~section eleven, article three, chapter thirty-three, sections six, seven and eight, article eleven, chapter thirty-three and section twenty-five, article twelve, chapter thirty-three of the Code of West Virginia of 1931, as amended,~~ W. Va. Code §§33-3-11, 33-11-6, 33-11-7, 33-11-8 and 33-12-25, refuse to renew, or may revoke or suspend the license of any such person or, in lieu thereof, the commissioner may, at his discretion, order such person to pay to the state of West Virginia a penalty in a sum not to exceed that imposed by said sections of said code, and the commissioner may, pursuant to ~~section eleven, article two, chapter thirty-three of said code~~ W. Va. Code §33-2-11, order such person to discontinue such illegal, improper or unjust transaction of insurance and to adjust and pay obligations as they become due.

Insurance Commissioner
Legislative Rule
Title 114, Series 14

UNFAIR TRADE PRACTICES
TITLE 114, SERIES 14

BRIEF SUMMARY OF RULE

This rule clarifies existing standards and inserts additional standards with respect to unfair claim settlement practices. The rule will be used by the Insurance Commissioner to ensure that consumers are being treated fairly and equitably by those in the insurance industry. The rule also puts the insurance industry on notice as to what the Insurance Commissioner considers to be a fair (or unfair) claim settlement practice.

Insurance Commissioner
Legislative Rule
Title 114, Series 14

UNFAIR TRADE PRACTICES
TITLE 114, SERIES 14

STATEMENT OF CIRCUMSTANCES

With the enactment of Senate Bill 418 during the 2005 regular session, the Legislature prohibited a third party insurance claimant from bringing a private cause of action against an insurer for an unfair claim settlement practice. The legislation also changed the administrative process under which a third party claimant files a complaint with the Insurance Commissioner. Given these changes, the Legislature perceived the urgent need for updating the standards for fair (and unfair) claim settlement practices and accordingly authorized the Insurance Commissioner to promulgate an emergency rule for this purpose. The rule will be used by the Insurance Commissioner to ensure that consumers are being treated fairly and equitably by those in the insurance industry. The rule also puts the insurance industry on notice as to what the Insurance Commissioner considers to be a fair (and unfair) claim settlement practice.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Unfair Trade Practices (Title 114, Series 14)

Type of Rule: X Legislative ___ Interpretive ___ Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Victor.Mullins@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

The rule will have no additional fiscal impact upon state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	2006 Increase/Decrease (use "-")	2007 Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	None	None	None
Personal Services	None	None	None
Current Expenses	None	None	None
Repairs & Alterations	None	None	None
Assets	None	None	None
Equipment	None	None	None
Other	None	None	None
2. Estimated Total Revenues	None	None	None

Rule Title: Unfair Trade Practices (Title 114, Series 14)

3. Explanation of above estimates (including long-range effect):
Please include any increase or decrease in fees in your estimated total revenues.

N/A

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Date: July 29, 2005

Signature of Agency Head or Authorized Representative

Jane L. Cline, Insurance Commissioner

Insurance Commissioner
Title 114, Series 14

FILED
2005 AUG 30 P 4: 13
OFFICE WEST VIRGINIA
SECRETARY OF STATE

ATTACHMENT TO QUESTION 2 (d):

A. Subsection 1.1(c)

A comment was received stating that "the rule should also exempt medical malpractice, boiler & machinery and bonds." Another commentator suggests that medical professional liability claims be excluded from the rule.

The Commissioner responds that she can find no statutory authority for her to propose the requested exemptions. While W. Va. Code § 33-11-6(i) exempts medical professional liability claims from the provisions of W. Va. Code § 33-11-4a, the Commissioner believes that this does not equate to a blanket exemption of such claims from the Unfair Trade Practices Act ("UTPA") or the Act's complementary rules. W. Va. Code § 33-11-4a created a new procedural process by which certain third party complaints will be treated. Medical professional liability claims and workers compensation claims are exempted from that process. There is no statutory mandate, however, that exempts such claims from being reviewed under the remaining, more substantive, provisions of the UTPA.[1] Accordingly, the Commissioner declines to include in the proposed rule the requested exemptions.

B. Subsections 2.2, 2.3 and 2.8

One commentator submits that the definitions of "claimant" (subsection 2.2), "first party claimant" (subsection 2.3) and "third party claimant" (subsection 2.8) are ambiguous and could lead to unintended consequences. This commentator also states that the definition of "claimant" "could give rise to arguments for damages under the Unfair Trade Practices Act ("UTPA") for family members or others who do not actually qualify as a first or third party claimant." The commentator further asserts that the definitions of "first party claimant" and "third party claimant" "could result in 'third part[y] claimants' qualifying as 'first party claimants' and improperly entitling them to damages only afforded to first party claimants." It is recommended that the definitions be clarified.

The Commissioner agrees that the definitions could be misconstrued and therefore will change the subsections as follows:

2.2. "Claimant" means either a first party claimant, a third party claimant, or both~~, and includes such claimant's designated legal representative, a designated member of the claimant's immediate family, or any other person named by the insured who may legally act on his or her behalf and who so acts without compensation of any kind~~.

2.3. "First Party Claimant" or "Insured" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance

[1] This includes W. Va. Code § 55-7B-5, which prohibits a third party from bringing a lawsuit against a medical professional liability insurer but is silent with respect to administrative complaints filed with the Commissioner.

policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract _*for which premiums were paid by the claimant or on the claimant's behalf*_.

2.8. "Third Party Claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer _*for which premiums were not paid by the claimant or on his or her behalf*_.

C. Subsection 2.14

One commentator remarks that "the definition seems internally inconsistent in that it adopts the standard set forth in McCormick v. Allstate, 505 S.E.2d 454 (W.Va. 1998), as something that does not constitute an act of 'actual malice,' yet finds an egregious act to be one that is 'irresponsible.' 'Irresponsible' is analogous to negligence yet 'simple negligence' is not an 'egregious act' as per the definition."[2] Another commentator states that the "modifier 'simple' should be removed from 'simple negligence' because as written this means that standard 'negligence' alone can constitute egregious conduct." Another commentator says that the definition "appears to be contrary to its English language definition," noting that words such as "irresponsible" and "reckless" are not included in the definition provided by Webster's Dictionary.

The Commissioner agrees that the inclusion of "clearly irresponsible" could create an inconsistency within the definition. The Commissioner further notes that the word "simple" will have the effect of modifying "negligence" in a manner that is not intended. Accordingly, "clearly irresponsible" and "simple" will be deleted from the proposed rule. The Commissioner declines to follow the recommendation that the definition follow Webster's Dictionary, as the rule definition must be put in the context of determining unfair claims settlement practices.

Comments were received on the procedure regarding a finding of "egregious act" by the Commissioner. Two commentators note that neither the definition in subsection 2.14 nor anything else in the rule indicates who will make the finding, at what stage such finding will be made, who bears the burden of proof and what that burden is. The Commissioner responds that the procedure regarding hearings remains unchanged. The preliminary paragraph to W.Va. Code 33-11-6 (which was not changed in Senate Bill 418) provides that the Commissioner after notice and hearing must first determine if a person has violated *any* provision of Article 11 of Chapter 33 or rules promulgated thereunder. If such a determination is made, the Commissioner may "at his or her discretion" order any number of forms of relief, including restitution from the newly-created Unfair Claims Settlement Practice Trust Fund if the claimant has suffered damages from an "egregious act." The applicable hearing procedures are found in W.Va. Code 33-2-13 and 114 CSR 13. Thus, hearings to determine whether an "egregious act" has occurred will proceed in the same manner as other hearings, and determinations as to whether a particular violation has occurred will continue to be made in the same manner and under the same standards of proof as similar determinations have

[2] Several other commentators submit a similar comment.

heretofore been made with regard to other violations of the Insurance Code. The Commissioner further notes that a procedural rule addressing hearings on third party administrative complaints will soon be submitted to the Secretary of State for approval.

D. Subsection 3.1

One commentator expressed concerns over having to retain "hard copies" of forms provided to a claimant in the claims file. The Commissioner points out that insurers can either retain a copy of the form or make a specific notation in the file of what form was provided. Accordingly, the notation option should not present a problem to those companies that do not wish to place hard copies of forms in their claim file. The same commentator also recommends clarification as to what forms the subsection is referring. The Commissioner responds by stating that the term "forms" commonly denotes insurance documents that are approved by the Commissioner and subsequently distributed to policyholders. Thus, the Commissioner believes that a clarification in the rule is unnecessary.

Two commentators believe that this subsection could be read to include documents protected by attorney/client privilege. One of these commentators suggested that the words "under subpoena" be included after "duly appointed designee." The language in question is current rule language and not part of the proposed amendments. Notwithstanding this, the Commissioner believes that the attorney/client privilege does not need to be expressly preserved before such privilege can be properly evoked.

Two comments were received stating that the proposed provision is unclear with respect to how an oral communication could be dated. The intent of this subsection is to allow the Commissioner an opportunity to reconstruct events relating to the processing of a claim. The substance and date of any oral communication should be duly noted in the claim file. The Commissioner agrees that this section needs clarification. Therefore, this section will be changed as set forth below:

3.1. File and record documentation. -- The insurer's claim files shall be subject to examination by the commissioner or by his or her duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. All communications and transactions emanating from or received by the insurer shall be dated by the insurer. A notation of the substance and date of all oral communications shall be contained in the claim file. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.

E. Subsection 4.1

A comment was received stating that the inclusion of the undefined term "beneficiary" may be interpreted to mean that the subsection is applicable to third party claimants. It is argued that, should this section apply to third party claims, the subsection would require disclosure of an insured's policy limits, which "may subject the insured to additional or exaggerated claims." The

commentator is also of the opinion that the insured "must first consent to the release of policy limits information in the claim process before suit is filed and the information is subject to disclosure." It is suggested by several commentators that the words "or beneficiary" be deleted so that this subsection can only be construed to apply to first party claims.

One commentator believes that the new language may be interpreted to mean that the insurer must provide coverages to the claimant that do not apply to the underlying facts of the claim. This commentator further remarks that the intent of the subsection is unclear with respect to the statement that "additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim."

A couple of commentators believe the proposed language contradicts West Virginia case law as the West Virginia Supreme Court of Appeals has stated, "looking at our own precedent, we can find no authority requiring an insurer to notify its insured of available coverage following notification of a loss or to advise its insured as to the limits of such coverage." It is also suggested that this subsection "could place insurers in the inappropriate position of rendering legal advice to insureds."

Another commentator states that the current language is sufficient. It is argued that the replacement language goes far beyond the NAIC model language and could result in a retroactive violation should a court find coverage that was not intended by the policy.

Another commentator notes that the proposed rule substitutes new language for language found in the corresponding section of the NAIC model and that this change "seems inconsistent with recent efforts to bring West Virginia's insurance market into the mainstream" and to the state's general efforts to adopt model language into the overall statutory framework.

In response to the above comments, the Commissioner notes that the proposed subsection, while somewhat similar, does veer from model language. After further consideration, the Commissioner is of the opinion that the existing language of subsection 4.1 (which is model language) more clearly conveys the objective of the subsection than the proposed language. Accordingly, subsection 4.1 as it appears in the current version of the rule will remain unchanged.

F. Subsection 4.4

One commentator remarks that this subsection "would contradict approved policy provisions now in place that impose reasonable time frames without specific limitations." Another commentator submits a similar comment. The Commissioner responds that such ambiguity in policies is exactly what the subsection seeks to cure.

Another commentator states that this subsection is "inconsistent with applicable statutes of limitations" and "contrary to W. Va. Code §33-6-31(e)(ii) concerning 'John Doe' UM claim notification requirements that require a claimant to notify an insurance company within 60 days of

the accident."[3] The Commissioner agrees that this subdivision needs clarification so that it will be consistent with relevant time frames set forth in the West Virginia Code or West Virginia Code of State Rules. Accordingly, the subsection will be changed as follows:

4.4. Time limit for notification of claim. -- Except where a time limit is specified in the policy or set by statute or rule, no insurer may require a first party claimant to give notification of a claim or proof of claim within a specified time.

G. Subsection 4.5

One commentator objected to this subsection applying to third party claims, requests that the language of the subsection be clarified and raises privacy issues concerning claims involving different coverages. Another commentator similarly states that this subsection is unclear as to its intent.

Another commentator remarks that subsection 4.5 might lead to "simple, isolated calculation errors that do not materially affect the payment or value of the claims" being deemed a communication that misrepresents a pertinent policy provision. This commentator posits that "so long as the partial payment is not improperly designated as a full and complete payment, such an explanation should not be necessary."

Another commentator believes this subsection "offers no real consumer protection" and adds that the "time lost in creating appropriate disclosures or determining 'all amounts' that may be paid, could result in significant hardship for the consumer."

Another commentator says that partial and advance payments are routinely made, particularly with regard to large losses, and notes that any payment less than policy limits could be construed as a misrepresentation under this subsection.

Another commentator remarks that the proposed rule would require an insurer to include a statement identifying coverage when a payment is being made to a third party, which is contrary to W.Va. Code § 33-11-4(9)(j). Another commentator likewise suggests that extending such a duty to third party claimants has never been recognized by the West Virginia Supreme Court of Appeals.

Another commentator states that "the language 'which should be included' is subject to differing and varied interpretations . . . [and] will result in a lot of claims of unfair practices that are without merit." Another commentator believes this language "is vague and ambiguous and does not contemplate situations involving disputes as to settlement value."

The Commissioner concurs that the proposed subsection should not apply to third party claims in that such a position is inconsistent with current statutory and case law. The Commissioner also notes that the subsection could have the unintended consequence of causing delay. Moreover,

[3] Several other commentators claim that the rule might supplant statutory time frames.

the Commissioner already has the authority to stop misleading communications under the Unfair Trade Practices Act. Therefore, subsection 4.5 will be deleted from the proposed rule.

H. Subsections 5.1, 5.2, 5.3, 5.4. 6.2 and 6.7 (time frame reductions)

One commentator states that the "overall reduction of time for claim handling activities from 15 working days to ten 10 working days is adverse to the interests of the insurance industry and will lead to an increased number of timeliness violations." It is argued that the shorter time frames may be susceptible to a purposeful "barrage" of communications and will require additional time and effort on the part of a claim representative to explain why more than ten (10) working days is needed to complete certain tasks. Essentially every individual who submitted comments asserts that the proposed time frame reductions are an unreasonable burden. It is strongly urged by these commentators that the Commissioner not seek a reduction of the time frames.

The Commissioner responds by duly noting the fervent objections to this proposal. The Commissioner also notes that additional personnel may be needed for a company to comply with the shorter time frames, which would likely increase the expenses of a company and thus would drive up the cost of insurance to consumers without a significant improvement to the process. Therefore, the Commissioner agrees that the time frames should remain at fifteen (15) working days.

I. Subsection 5.1

One commentator states that the additional provision in this subsection concerning notice to an agent is problematic because of the definition of "agent" does not appear to cover selling agents, extensive training will be required, the term "promptly" is not defined and the subsection does not address independent selling agents or sales via the Internet. It is suggested that the language mirror that of subsection 6.2.

Another commentator believes that subsection 5.1 should be clarified to say that whenever the policy provides that an agent cannot receive a claim, then there is no duty on the part of such agent to send a written communication informing a claimant of that provision.

The Commissioner notes that agents already have such a duty under the current rule (at subsection 6.2): "A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent notifies the person filing the claim that the agent is not authorized to receive notices of claim." Moreover, the basis for this requirement is obvious – insureds quite understandably believe that they are communicating with their insurer whenever they communicate with the individual with whom they usually deal concerning their insurance needs or concerns. Given that the current language of subsection 6.2 adequately addresses the matter in question, the Commissioner will delete, for consistency purposes, the proposed language in subsection 5.1.

J. Subsection 5.2

A comment was provided stating that there is no "statutory authority that would require insurers to submit complete copies of claim files to the Department of Insurance" as this subsection would require after a request by the Commissioner. This commentator further states that "insurers are required to provide access to the complete claim files only during reasonable hours at the offices where the files are regularly maintained" in accordance with W. Va. Code § 33-2-9(i)(2). The Commissioner disagrees with these comments and responds by stating that it is immaterial whether or not "claim files" is referenced in the subsection. Even if "claims files" is omitted, the Commissioner still has the authority to obtain virtually every document within the claim file. Moreover, the existing language of subsection 3.1 broadly provides that "[t]he insurer's claim files shall be subject to examination by the commissioner or by his duly appointed designees." Because the phrase "and claim files" is unnecessary, the Commissioner will strike it from the subsection.

Another commentator states that this subsection would require production of documents "which could easily include information protected by federal and state privacy acts or by attorney/client privilege." Two other commentators raise the same concern. The Commissioner believes that the privilege protecting such documents from disclosure does not need to be expressly preserved before such privilege can be properly evoked.

Another commentator suggests that the language "all issues raised by the complainant" is overly broad and should be limited to only that information material to the claim. The Commissioner believes that it should not be left to the respondent of an inquiry to choose what he or she feels is relevant to the claim and then respond accordingly. If the respondent is without information on a topic raised by the inquiry, the respondent can easily say so.

Another commentator remarks that "the change from 'receipt of the inquiry' to the 'date appearing on the inquiry' significantly reduces the insurer's ability to respond." The Commissioner does not believe the change is unreasonable. Because the inquiry is being sent by the Commissioner, the alleged problems associated with a "date of inquiry" provision are not prevalent. The Commissioner will not create a situation where the respondent is inundated with inquiries and thus "trap" a person or company into a violation. Nor will the Commissioner date an inquiry and send it out days later. The Commissioner realizes that the U.S. Mail system can be less than efficient at times and will take that into consideration when appropriate. However, the U.S. Mail system is predictable enough so that a person or company cannot habitually fall back on the position that the inquiry arrived later than usual.

K. Subsection 5.3

Two commentators note that this subsection does not set forth whether the time requirement for the response is based on the date it is made or the date it is received. The Commissioner agrees that a clarification is needed and will insert "of receipt by the insurer" after the word "days" in the proposed subsection. This change will make the subsection more consistent with the majority of the other rule provisions containing such a time frame.

L. Subsection 6.1

A commentator remarks that the language of this subsection is "vague and ambiguous, subject to a myriad [of] interpretations and apparently left to the discretion of the Commissioner and/or juries who may consider first party 'bad faith' claims without regard to evidentiary standards or further definition."

Another commentator objects to this subsection as it equates the duty of an insurer to a third party claimant to that owed to a first party claimant.

The Commissioner responds that the proposed subsection reinforces what is already statutorily required pursuant to W. Va. Code § 33-11-4(9)(b),(c) and (f). All of the referenced statutory provisions apply equally to first and third party claims. Moreover, it has always been the fact-finder's province to determine the parameters of what is "prompt" and "reasonable," and that duty has not been modified by this subsection.

M. Subsection 6.2

One commentator states that this subsection, when read together with subsection 6.3, "would appear to impose a maximum time frame to complete investigation of a claim" and requests that a clarification be made. Another commentator submits a similar comment. The Commissioner does not believe that subsections 6.2 and 6.3 together create a mandatory time period within which the investigation must be completed. Subsection 6.2 simply defines when an investigation must be commenced and subsection 6.3 states that an insurer's decision to deny the claim or make an offer must be done within ten (10) days after the investigation is complete. Neither subsection requires an investigation to be completed within a set time period.

Several commentators suggest that the rule language be clarified with respect to what type of claims the subsection applies. The Commissioner responds by stating that the first and third sentence of subsection 6.2 is applicable to first and third party claims and the second sentence is applicable to first party claims only. The Commissioner will place each sentence in a separate subdivision for added clarification.

N. Subsection 6.3

A commentator remarks that the word "completion" is vague and ambiguous and "does not contemplate investigations which continue and are on-going or situations where bodily injury claims result in on-going medical treatment and pending medical bills, questions or disputes involving liability or coverage." The Commissioner believes that the word "completion" is not susceptible to many interpretations. If an investigation is continuing or on-going, then it should be clearly apparent that the investigation is not complete. Likewise, if the claim remains open due to pending medical service, the investigation would also remain open to determine whether the service is covered under the policy. Questions or disputes concerning liability or coverage are possible consequences of an investigation and subsequent decision by the insurer and thus are immaterial to this new subsection.

Accordingly, the subsection will remain as proposed.

O. Subsection 6.4

Several commentators maintain that the disclosure of an insured's liability limits to a third party is a violation of an insured's duty to its insured and may raise privacy concerns. One of these commentators argues that the new language is silent as to how an insurer must carry out the requirement to advise a claimant that the claim exceeds policy limits and that "[i]t is prejudicial to the interests of the carriers and potentially the tortfeasor in such situations for an [insurer] to reveal the evaluation that might expose the excess carrier and potential personal assets of the tortfeasor." It is further noted by this commentator that this new language would require "extensive re-training" and potentially create a need for the development of additional forms.

Several commentators believe that subsection 6.4 improperly requires first and third party claims to be calculated in the same manner, a requirement which is argued ignores the different sources of the duties to first and third parties. Another commentator similarly states that "the duties owed to a third party are dictated by common law principles, while first party claims are more directly spelled out by contract."

The Commissioner agrees that the proposed language may raise privacy issues or would be difficult, if not impossible, to apply and thus should be deleted from the proposed rule.

P. Exiting Subsection 6.4 (deleted from proposed rule)

One commentator requests that the Commissioner keep the current provision found at subsection 6.4 "as it allowed simple denials to be handled very quickly, without incurring additional expense." This could prevent an insurer from having to open a claim file, incurring loss adjustment expense and reporting the incident as a "claim" against the insured's record.

The Commissioner concurs that the deletion of existing subsection 6.4 may be adverse to the interests of insureds and therefore will reinstate the subject language within subsection 6.6 of the proposed rule.

Q. Subsection 6.5

A comment was received that this subsection is "unclear when the Commissioner may become involved in reviewing such issues . . . contains vague and ambiguous terms . . . and apparently imposes a new standard" as set forth in subdivision g. Another commentator adds that this subsection is "fundamentally unfair and unduly burdensome." Another commentator also questions how the Commissioner will determine the adequacy of a settlement offer and that this subsection creates a process that may be very subjective. Another commentator states the proposed subsection is "inherently arbitrary" and the "criteria set forth go far beyond any standard of good faith and place the Commissioner in the position of second-guessing not only the insurer's business judgment, but also the insurer's legal and factual analysis of the claim."

The Commissioner responds that this subsection is intended to provide guidance to claimants and insurers to what the Commissioner will consider with respect to settlement offers. With the passage of Senate Bill 418, the Commissioner will routinely have to determine if an insurer has attempted to settle the subject claim in good faith. Without question, the overwhelming majority of complaints brought before the Commissioner will involve the settlement amount offered by the insurer. An unreasonably low offer by the insurer certainly rises to an act of bad faith in violation of the Unfair Trade Practices Act. Currently, there is no framework to which the Commissioner can turn in order to decide whether an offer is unreasonably low. The proposed subsection provides that framework. Having such a rule provision promotes fairness and uniformity, which is especially desirable given the fact that it is expected that many different hearing examiners will soon be conducting third party administrative hearings in order to satisfy the Commissioner's duties under Senate Bill 418.

Two commentators believe that this subsection conflicts with W. Va. Code § 33-11-4a(g), which states that "[a] good faith disagreement over the value of an action or claim or the liability of any party to any action or claim is not an unfair claims settlement practice." As the quoted language suggests, the Commissioner must determine whether a good faith disagreement over the claim's value exists. If, for example, an insurer offers $10,000 on a claim it knows, or should know, is worth $50,000, such a situation should not be removed from the Commissioner's review simply because it falls under the guise of a good faith disagreement concerning the value of a claim. The $10,000 offer should be called what it actually is, an unreasonably low offer. Thus, if the Commissioner finds that an insurer made an unreasonably low offer, it follows that there was no good faith disagreement over the value of the claim and W. Va. Code § 33-11-4a(g) is therefore inapplicable.

It is also asserted by several commentators that subdivision d violates the attorney-client privilege. It is suggested that the subdivision be eliminated or clarified as to which counsel this provision applies. One commentator also states that "the proposed factors are limited and give insurers virtually no means to present their own positive evidence of claim value, but rather require them to react to claimant and/or the commissioner's evidence of value or present evidence only on how they considered claimant value evidence." The Commissioner responds by stating that the standards contained within the proposed subsection is a listing of what she must consider should such evidence be presented to her. The subsection does not require an insurer or claimant to supply the information referenced in the subdivisions. While non-privileged information may have to be produced pursuant to other code or rule provisions, this is not the intent of subsection 6.5. If the insurer wishes to offer any evidence that falls under the subdivisions of 6.5, it may do so and the Commissioner cannot refuse to consider such evidence. However, the weight or value given to this evidence is left to the discretion of the Commissioner. Again, the subsection is a framework to which the Commissioner (or hearing examiner) should work within in order to decide whether an offer was unreasonably low. Notwithstanding this and even though it is the opinion of the Commissioner that subdivision d would not trump the attorney-client privilege, the Commissioner agrees to delete the reference to "advice of counsel regarding the likelihood of recovery in excess of policy limits."

Another commentator notes that the inclusion in subdivision f of permitting the Commissioner to consider "the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter" is irrelevant to the question of bad faith and should be deleted. The Commissioner disagrees. Such a determination by the insurer is, at the very least, instructive as to whether the insurer believed there should be coverage or how it valued the claim. If an adjuster provides an opinion that the insured was at fault and would likely be found liable in court and the insurer subsequently denies the claim for no valid reason, then this would certainly be relevant to whether the insurer is acting in good faith.

Another comment was received stating that the information discussed in this subsection may be proprietary and thus the subsection "should clearly provide that any [claim handling] tools, when disclosed to the Commission, shall remain confidential and not open to public disclosure, including disclosure to the claimant or claimant's attorney." The Commissioner believes that such a blanket confidentiality provision is unwarranted. If the insurer is concerned about the release of confidential or proprietary information, the insurer can make such a concern known when the information is requested or before the release of the information. Thus, it is the Commissioner's opinion that such matters should be considered on a case-by-case basis.

Another commentator suggests that an additional subdivision be included: "Independent expert opinions on medical evidence and damages calculations." The Commissioner agrees that "expert opinions" should be an expressed factor requiring consideration. The Commissioner is also of the opinion that the subsection, for the sake of clarity, does not need to be a separate subsection but could be incorporated into subsection 6.4. Accordingly, the subsections 6.4 and 6.5 will be modified as follows:

~~6.2.~~ 6.4. Offers of settlement. --

(a) In any case where there is no dispute as to coverage ~~or~~ and liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

(b) No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

3. The extent to which the insurer considered the advice of its claims adjuster as

to the amount of damages;

4. The extent to which the insurer considered the opinions of independent experts;

5. The procedures used by the insurer in determining the dollar amount of property damage;

6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and

7. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is or is not below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

R. Subsection 6.6

A commentator claims that a formal written denial should not be required for every denial because many denials are merely responses to telephone calls about coverage for losses that are obviously not covered. This commentator argues that if a written denial is required for every such inquiry, insurers will unnecessarily incur additional costs in establishing claim files, etc. in response to such inquiries.

The Commissioner believes that the deletion of the language in subsection 6.6, together with the deletion of existing subsection 6.4, may be adverse to the interests of insureds and therefore agrees to reinstate the subject language at subsections 6.5 and 6.6 of the proposed rule.

S. Subsection 6.7

One commentator states that the "proposal to change this delay notification from first party claims to all claims is . . . unduly burdensome." The Commissioner believes that both first party and third party claimants should be kept informed of the status of a claim and that the value of the notice to third party claimants outweighs the burden placed on insurers. With such a notice requirement, the claimant will know where the matter stands and thus can be more proactive in getting the claim settled. It also requires that the insurer is aware of what is needed to move the claim closer to settlement.

Two commentators interpret the revisions to subsection 6.7 as eliminating the requirement that claimants file proofs of loss. The Commissioner believes this misconstrues the proposed revision and that other sections of the rule, such as subsection 6.2 (insured has duty to furnish all statements that the insurer believes are reasonably required), maintain the right of the company to require a proof of loss.

Another commentator remarks on the exemption from the requirements of this subsection – essentially, a requirement that the insurer notify a claimant of any reason for a delay in an investigation – from cases involving suspected arson to any case in which fraud is suspected. Instead of limiting the exemption to insurers who can give a "reasonable basis supported by specific information" that a claimant "fraudulently caused or contributed to the loss by arson," the subsection has been limited to cover only those situations in which it can be shown that the claimant "fraudulently caused the loss." Several commentators complain that the deletion of the words "contributed to" will increase the burden of proof that insurers must meet to use the exemption. The Commissioner agrees that the exemption should not be restricted in such a manner and will reinstate the "contributed to" language.

Another commentator suggests that there should be an exception to the notice requirement for any claim where the claimant is represented by an attorney. Two other commentators recommend that an exemption should apply to pending litigation. The Commissioner believes that the notice requirement is an important step in keeping claimants informed and is not overly burdensome on insurers. If the delay is often the fault of the claimant's counsel as one commentator suggests, then it would only seem beneficial to have this pointed out to the claimant so that he or she may "refocus" the attorney's actions. Therefore, the Commissioner is of the opinion that the suggested exemptions should not be contained within this subsection.

Another commentator also suggests that the thirty (30) day intervals be increased to forty-five (45) days considering that thirty (30) days is often too short of a time frame. The Commissioner agrees and will make the change in the proposed rule.

T. Subsection 6.10

One commentator believes that the provision requiring a carrier to explain its specific reason for disclaiming liability because of a breach of policy provisions by the policyholder is problematic in that it does not take into account relevant case law, which instructs insurers on what they should consider prior to voiding a policy when an insured fails to cooperate.

Another commentator states that this subsection is "unclear if the insurer must provide an explanation if disclaiming coverage, if disclaiming liability, or both." A similar comment suggests that this subsection confuses the terms "liability" and "coverage."

Another commentator posits that the subsection's requirement "is a serious breach of the insured's privacy rights" in that a third party claimant "should not be privy to matters between the contracting parties, particularly sensitive items such as the insured[']s conduct."

Upon review of this subsection, the Commissioner is of the opinion that the language may result in undesirable consequences and is not in step with W. Va. Code § 33-11-4(9)(e). Therefore, the Commissioner will delete this subsection from the proposed rule.

U. Subsection 6.12

One commentator objects to this new subsection as "it imposes an undue and likely unattainable responsibility on insurers to verify the data of others over which it presumably has no control." Two other commentators submit a similar comment. Another commentator notes that "this proposal would significantly curtail an insurer's ability to establish the value of a claim and would lead to additional delays in settling claims where coverage, damages &/or negligence are reasonably clear." Another commentator believes that the rule creates "an ambiguous standard that would make it impossible for an insurer to be sure they have achieved compliance."

Several commentators believe that this subsection is unclear as to how insurers are to measure the accuracy of information. One commentator suggests that "an insurer should simply be prohibited from using information that it knows to be inaccurate." Another commentator argues that the last sentence in subdivision a is "counterintuitive to the first part of this subsection," with the last sentence requiring "an insurer to accept as valid any information presented by a claimant, regardless of documentation." Another commentator believes that insurers should not be held responsible for data supplied by the insured, the claimant, or their representatives.

The Commissioner responds that an insurer is currently prohibited from relying on inaccurate or incorrect data when adjusting or settling claims. Subsection 6.12 was an attempt to further define this prohibition. After reconsidering the subsection, however, the Commissioner is of the opinion that the provisions are unnecessary and should be removed from the proposed rule.

V. Subsection 6.17

Several comments were received stating that a broad reading of this subsection may invalidate incentive plans that are directly or indirectly tied to claim denials. Another commentator similarly states that all claim denials create "potential savings to the insurer," and so company endeavors such as profit sharing, employee bonuses and stock dividends could potentially be affected by this subsection. One commentator suggests that the subsection be modified "to reflect an important distinction between inappropriate denial and proper ones." Another commentator suggests that the word "solely" be inserted after the word "based" and the word "improperly" come before the word "denying."

The Commissioner agrees that a clarification of the language in this subsection is needed so as not to nullify proper incentive plans that are offered by companies. Accordingly, the subsection will be changed as follows:

6.15. Compensation based on claim denials. -- No insurer may offer incentives or compensate its employees, agents or contractors based on savings to the insurer as a result of improperly denying the payment of claims.

W. Subsection 6.18

One commentator argues that the subsection violates the First Amendment (free speech) of the U.S. Constitution.

The Commissioner agrees that the subsection may violate the First Amendment. Moreover, if the Commissioner finds that an insurer is advising claimants not to seek the services of an attorney or a public adjuster and this advice is improper under the circumstances, she can still take regulatory action against the company under the Unfair Trade Practices Act. Therefore, a specific rule provision is unnecessary. The language of this subsection will be deleted from the proposed rule.

X. Subsection 6.20

A commentator remarks that the exceptions to the release of income information "overlooks personal injury claims in which permanency is alleged and would thus deprive a carrier of the right to investigate if the claimant is in fact permanently injured or whether the claimant is engaged in some work activity thus defeating certain claims." Another commentator suggests that the Commissioner consider including types of claims that involve fraud considering that financial motives are behind fraudulent claims. Likewise, another commentator states that the claimant's financial picture is critical if the insurer suspects fraud. Another commentator remarks that the subsection "would conflict with existing policy language" given that many policies require the policyholder to show records such as tax returns or bank statements following a loss.

The Commissioner notes that an undesirable effect of the subsection could be the hampering of the identification of fraudulent activity. The Commissioner also agrees that the language of the subsection could possibly conflict with approved policy forms. Therefore, the Commissioner will remove this subsection from the proposed rule.

Y. Subsection 6.22

One commentator calls for the elimination of this subsection as he believes that subrogation is "incongruent with the Unfair Trade Practices Act." Two commentators suggest that this subsection could encourage insurers to obtain the services of outside counsel or a collection agency, which are generally more expensive than in-house resources. Another commentator states that the "subsection will increase the cost of insurance claims, grant to claimant's unintended benefits and effectively disallow provisions of insurance contracts already approved by the [Commissioner]."

The Commissioner responds that the primary purpose of the subsection already appears in Section 114-14-7.3.a. After considering the parts of the proposed subsection that are in addition to that of subsection 7.3, the Commissioner believes that the language may have unintended effects or is unnecessary. Accordingly, the Commissioner will delete this subsection from the rule.

Z. Subsection 6.23

One commentator objects to this subsection "as it would eliminate any ability of a carrier to

settle a claim globally."

The Commissioner concurs that the subsection may have the undesired effect of obstructing the settlement of claims. Therefore, this subsection will be removed from the proposed rule.

AA. Subsection 6.24

One commentator questions why the subsection only applies to personal property insurance and not to all insurance. This commentator further states that this would require the creation of another form and questions what the public policy reason is for this subsection. Another commentator believes that a "legal trap" is created with the language "any element of a claim."

The Commissioner responds that the subsection should apply to all claims and not just those claims relating to personal property insurance. The Commissioner believes the public policy reason for having such a provision is obvious – to inform the claimant that the Insurance Commissioner is available to assist in the matter if needed. The Commissioner disagrees that a new form would be required by the subsection. The required information would simply be included in the denial notice which is already being sent to the claimant. The Commissioner disagrees that the reasonable and justified duty imposed by the provision's language creates a "legal trap."

BB. Subsection 7.2

Subparagraph E, paragraph 2, subdivision d of subsection 7.2 contains the only proposed change to section 7 of the rule. One commentator asserts that "taking a conditioning deduction from an NADA retail value may not fall within the 'physical attribute' characterization."

The Commissioner is unsure what is meant by this comment as conditioning deductions are presumably "built in" to the NADA retail values; therefore, the "physical attribute" deduction would not be applicable in such circumstances. This new language attempts to clarify that an insurer or valuation source can deduct for the conditioning of the vehicle only if it can be shown that the identified reason for the deduction directly equates to a measurable decrease in the vehicle's value.

CC. Section 8

A comment was received that the provisions of section 8 "would impose duties and obligations on insurers towards third-party claimants which equal or exceed the contractual duties and obligations owed by insurers to our own first-party insured policyholders." This commentator further argues that "this result is clearly contrary to established case law from the West Virginia Supreme Court regarding the duties an insurer owes to its own insured policyholders versus the duties it owes to third parties who lack any contractual relationship with the insurer."

The Commissioner is aware of the fact that an insurer's duties to first party claimants are different than its duties toward third party claimants, primarily due to the insurer's contractual relationship with the insured. The Commissioner further recognizes that when a law requires

insurers to treat third party claimants in a certain manner, the new duty may conflict with the contractual duties that insurers owe to their insureds. If such a conflict does develop, it invariably works to the detriment of insureds. After reviewing section 8 and the related comments, the Commissioner is of the opinion that the new section should be stricken from the proposed rule as the language of the section may directly conflict with the duties that an insurer owes its insured and because it was not the intent of the subsection to weaken the rights of insureds.

The Commissioner notes that many additional comments, all negative, were received concerning the provisions of section 8. However, because the Commissioner has decided to remove the entire section from the proposed rule due to the reasons expressed above, she will not restate and respond to the specific comments made about the language of the subsections.

DD. Section 9

One commentator states that the 45-day provision in subsection 9.1 is a shorter time frame than permitted under W. Va. Code § 33-11-4a(b)(4) and (5). This commentator fails to note that the 45-day time frame is not the period by which the insurer must attempt to "cure" the alleged violation, but instead is simply a deadline to advise the Commissioner of the status of negotiations.

Several commentators note that the 45-day period in subsection 9.1 begins upon receipt of the notice, which is inconsistent with subsection 5.2 where there is a proposed 10-day period for responding to any inquiry from the Insurance Commission. A consistent standard throughout is suggested. The Commissioner agrees that this needs clarification and will insert language in subsection 5.2 stating that the 10-day time period for responding to inquiries is not applicable to a third party complaint notice.

Another commentator questions whether the complaint needs to be in writing. The Commissioner responds that W. Va. Code § 33-11-4a(b)(1) requires that a third party administrative complaint be "on a form provided by the Commissioner" and W. Va. Code § 33-11-4a(b)(3) requires the Commissioner to provide "written notice of the alleged violation" to the person against whom the complaint is filed.

Another commentator remarks that subsection 9.2 differs from W. Va. Code § 33-11-4a(c). This commentator is concerned "that an insurer shall attempt to 'cure' by making an offer and the claimant simply will not respond, thus triggering the hearing process." The Commissioner will not proceed to hearing if she determines that the insurer "substantially corrects the circumstances that gave rise to the violation or offers to resolve the complaint in a manner found to be reasonable," which is the statutory language of W. Va. Code § 33-11-4a(b)(4).

The same commentator notes that this process "will require the Commissioner to review every offer made by an insurer once a third party administrative complaint is filed simply to determine if the subsequent offer constitutes either a 'substantial correction of the circumstances' as stated in the Code or whether the final offer was 'reasonable' as stated in the proposed rule." The requirement that the Commissioner determine reasonableness of a final offer is also contained in W.

Va. Code §§ 33-11-4a(b)(4) and (c). Therefore, the requirement is statutorily required and was not created by the proposed rule as this commentator implies.

This commentator also states that "the proposed rule is silent as to the second tier investigation permitted by the Code via the Consumer Advocate." The Commissioner is unsure what this commentator means when he says "via the Consumer Advocate." It is the Commissioner who has the authority to order further investigation and hearing. Hearings under this "second tier investigation" will proceed in the same manner as other hearings, and determinations as to whether a particular violation has occurred will continue to be made in the same manner and under the same standards of proof as similar determinations have heretofore been made with regard to other violations of the Insurance Code.

Other comments were received claiming that there is no clear definition of what constitutes "reasonable." It is argued that this leaves such a determination "open to the discretion of the Insurance Commission and the possibility that such determination may be subjective or inconsistent with other decisions." The Commissioner believes that an attempt to define "reasonable" would not clarify the matter. Courts and legal scholars have wrestled with defining this term for decades. Ultimately, it has been left for the fact-finder to determine what is or is not reasonable.

Another commentator suggests that subsection 9.2 is inconsistent with Senate Bill 418 because the need for hearing under the rule can be triggered when an offer should have been made and was not or was potentially unreasonable. The commentator argues that W. Va. Code § 33-11-4a(g) prohibits "any dispute" concerning the value of a claim from ever reaching the review of the Commissioner. W. Va. Code § 33-11-4a(g) states: "A good faith disagreement over the value of an action or claim or the liability of any party to any action or claim is not an unfair claims settlement practice." The commentator fails to note the phrase "good faith disagreement." It is incumbent on the Commissioner to determine whether there is a good faith disagreement over the claim's value. If, for example, an insurer offers $10,000 on a claim it knows, or should know, is worth $50,000, such a situation should not be removed from the Commissioner's review simply because it falls under the guise of a good faith disagreement concerning the value of a claim. The $10,000 offer should be called what it actually is, an unreasonable offer. Thus, if the Commissioner finds that an insurer made an unreasonable offer (or if the insurer should have made an offer but did not), it follows that there was no good faith disagreement over the value of the claim and thus W. Va. Code § 33-11-4a(g) is inapplicable.

Another commentator says the statutory prohibition against restitution for attorney fees and punitive damages be included in subsection 9.3 as well.

Another commentator argues that subdivision b of subsection 9.3 "creates a new standard of an 'egregious act' not contemplated by the statute" by permitting restitution without a finding that the act occurred within a larger "general business practice." The Commissioner disagrees with the premise that the Unfair Trade Practices Act ("UTPA") does not allow restitution for a single "egregious act." Subsection 9.3 of the proposed rule mirrors the UTPA, although the rule is limited to restitution for third party complainants and the statute covers a larger sphere of violations and

remedies. Both require a preliminary finding by the Commissioner "after notice and hearing" that the person has committed a violation of some sort. Compare the introductory paragraph of W.Va. Code § 33-11-6 (any violation of the insurance code) with subsection 9.3 of the proposed rule (limited to findings of "an unfair settlement practice in violation of 33-11-4(9)"). Under the UTPA, the preliminary finding triggers the Commissioner's authority to award certain remedies, including restitution to a claimant "who has suffered damages as a result of a general business practice *or* from an egregious act by a person *whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice*." The proposed rule likewise limits restitution awards to persons who have suffered damages from (1) a general business practice or (2) an egregious act. The UTPA clearly envisions an award of restitution on the basis of a single act, and the rule does the same.

After reviewing the proposed provisions of section 9, the Commissioner is of the opinion that this section is procedural in nature and would be better placed in a procedural rule that will soon be submitted to the Secretary of State for approval. Accordingly, the Commissioner will remove section 9 from this rule.

II. Section 10

One commentator requests that the entire section be reconsidered or deleted entirely. Another commentator states that section 10 "is wholly unnecessary" considering that "the duties that insurers owe to their policyholders and third-party claimants are determined by the statutory and case law of West Virginia." It is argued that claim violations are inevitable regardless of the amount of training held by insurers; therefore, section 10 "essentially guarantees violations of the rule." Another commentator believes that "the addition of this section will add significantly to the compliance burden and costs to the industry without providing any associated benefits to companies[,] insureds or third party claimants." This commentator also requests that the entire section be stricken.

Two commentators state that the passage of this section would require an amendment to claims manuals, immediate training of claims personnel, the creation of forms, and a significant investment by the carriers. It is also argued that the increased penalty amounts imposed by Senate Bill 418 is "a significant incentive to upgrade training to any adjusters who handle West Virginia claims."

Another commentator notes that the term "claims agent" is not defined. The Commissioner believes that the term "claims agent" is understood in the industry to connote those employees involved in the claims process.

Upon reconsidering the proposed section, the Commissioner is of the opinion that most of the provisions are unnecessary. The Commissioner already has the ability to ensure that agents are properly trained and can review all agent training materials pursuant to W. Va. Code § 33-2-9. The Commissioner does believe, however, that a general provision stating that the insurer should provide its claims agents with written standards concerning proper claim handling methods is beneficial.

Accordingly, this section will consist of the following language:

Communication of investigatory and claim processing standards. -- Within ninety (90) days of the effective date of this rule, every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims.