OIC Rules Coordinator

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To: OIC Rules Coordinator
Subject: Comments on R2025-05 First Prepublication draft comment

External Email

Good afternoon,

I am writing to express my strong support for the proposed changes to WAC 284-30-330 (4) in R2025-05. I have been dealing with bad faith claims for over 30 years now, and the change to WAC 284-30-330 (4) is not only very needed, but also long overdue.

In the last 10 bad faith cases my firm has handled, 7 of which were first party UIM claims, and 3 of which were assigned third party claims under a covenant judgment, the carrier has utterly failed to do any kind of reasonable investigation before denying payment on claims.

In first party claims, what we typically see is the carrier having their adjusters do what I refer to as a "passive" investigation, which means sitting back and waiting for the claimant or their attorney to go out and incur the expense of gathering all the medical records, employment records, or any other kinds of records and then sending them to the carrier versus the carrier doing what it is paid to do with the insured's premium dollars-do a **"proactive"** investigation, and obtaining these documents by themselves.

This is important because when carriers do a passive investigation, they are outsourcing the expense and work of an investigation to their insureds and their attorneys. For example, rather than asking for the insured to execute a medical release (which the insured is obligated to do under the policy) and incurring the significant expense of getting these records, they instead sit back and let the insured undergo the work and expense of getting these records. I have ***never*** in 40 years of practice seen a carrier ever offer to pay the insured for the expense of obtaining their records. When you multiply this practice by thousands of claims, the carriers are saving a massive amount of money in not having to order records and saving a massive amount of human tome and expense as well. What is the point of putting the cooperation clause into the insuring agreement requiring the signing of medical releases if it is never used?

Additionally, one an adjuster gets a medical release from their insured, they can be proactive and ask for reports from treating doctors to get claims investigated quicker and bring resolution about faster. Again however, this is rarely if ever done. Once again, carriers place this obligation on the insured and never compensate the insured for the hundreds of dollars they have to spend to get these reports for the lazy adjuster who just wants to sit back and wait for things to come to them. This is the art of passive investigation.

Adjusters can also call witnesses and get statements to expedite investigations if they want to be proactive-but the don't. Instead, they always ask the insured to get these for them.

The rational for the passive approach is that frankly, the definition of "investigation in WAC 284-30-320 is frankly still a bit weak. While the new definition is welcome, the definition should mirror the definition given in Websters or Blacks law dictionary, which typically include "actively taking steps to determine all facts of a matter". Without an affirmative obligation to engage in a pro-active investigation, carriers will continue to try and outsource the

expense of a reasonable investigation to their insureds and pocket the difference as profit for the Wall Street investors.

When we depose UIM adjusters and ask them how many claim files they handle simultaneously, we get some surprisingly high numbers, which explains the carriers reticence to see the definition of investigation change:

Q Okay. And as of 2023, let's just say mid-2023, how many UIM claim files were you adjusting or investigating or supervising?
A I – I don't remember.
Q Can you give me a ballpark estimate?
A Oh, I'd probably say maybe a hundred.
Q Okay.
A And that's being generous.

(New State Farm UIM adjuster)

A seasoned State Farm adjuster gave this answer:

All right. So tell me about your -- well, as of 2023, what was your claim file load in terms of -- in other words, how many claims were you handling at any one time?
A Prior to going to the unrepped team, usually somewhere in the neighborhood of 280, up to 330 or -40. Because that -- you know, it fluctuates, goes up and down.

An American Family UIM adjuster gave this answer recently:

Q. So if we say you -- how many claims do you have currently that you're working on?
A. Currently I would -- I think the last time I checked was about 170. And that's not -- that's exposures so that's -- so as an example, in one claim there might be two injured parties, so that would count as exposures. So it's not 170 claims that I have, it's 175 exposures.

I could easily provide many more examples like this. However, suffice it to say, carriers are deeply opposed to these changes because they know that when trying to keep their profit margins in place for Wall Street, they cannot afford to hire more adjusters to do reasonable investigations into claims, particularly if the state imposes new requirements on these already overloaded adjusters. 30 years ago, before Wall Street and the McKinsey Corp. changed how claims practices occurred in the 90s, adjusters had case loads of 30-40 cases, and the did active investigations. Now, the idea is to outsource as much of the claims handling expenses to the insured because they know that the vast majority of claimants don't have the resources to sue carriers for failing to investigate their claims and make bad offers. In the 5% or so of cases where they are taken to task for this, whatever they pay out is still a fraction of what they are making on the front end in failing to do a reasonable investigation and pay a fair amount on the claim. These amendments threaten those "passive investigation" profits they continue to rake in.

Subsection (11) 's amendment is also helpful in this regard, and I would strongly encourage the Commissioner to adopt this as well for the above stated reasons. Similarly, I applaud the new section in WAC 284-30-340 as carriers have been terrible about giving up any portion f claim files unless suit has been filed and they have to. The proposed change to WAC 284-30-360 reducing the response time to five days is also much needed, as delay is the insurer's best friend, and 15 days only added to it.

Once again, I strongly urge the Commissioner to adopt all of the changes referenced above, as well as those I have not addressed, as they are ll much needed.

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