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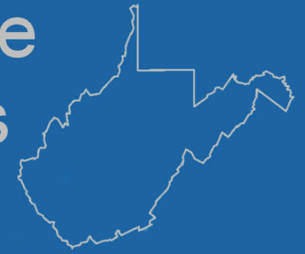
An Adjuster's Guide to Handling Claims in West Virginia



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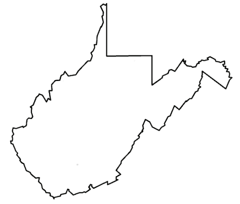

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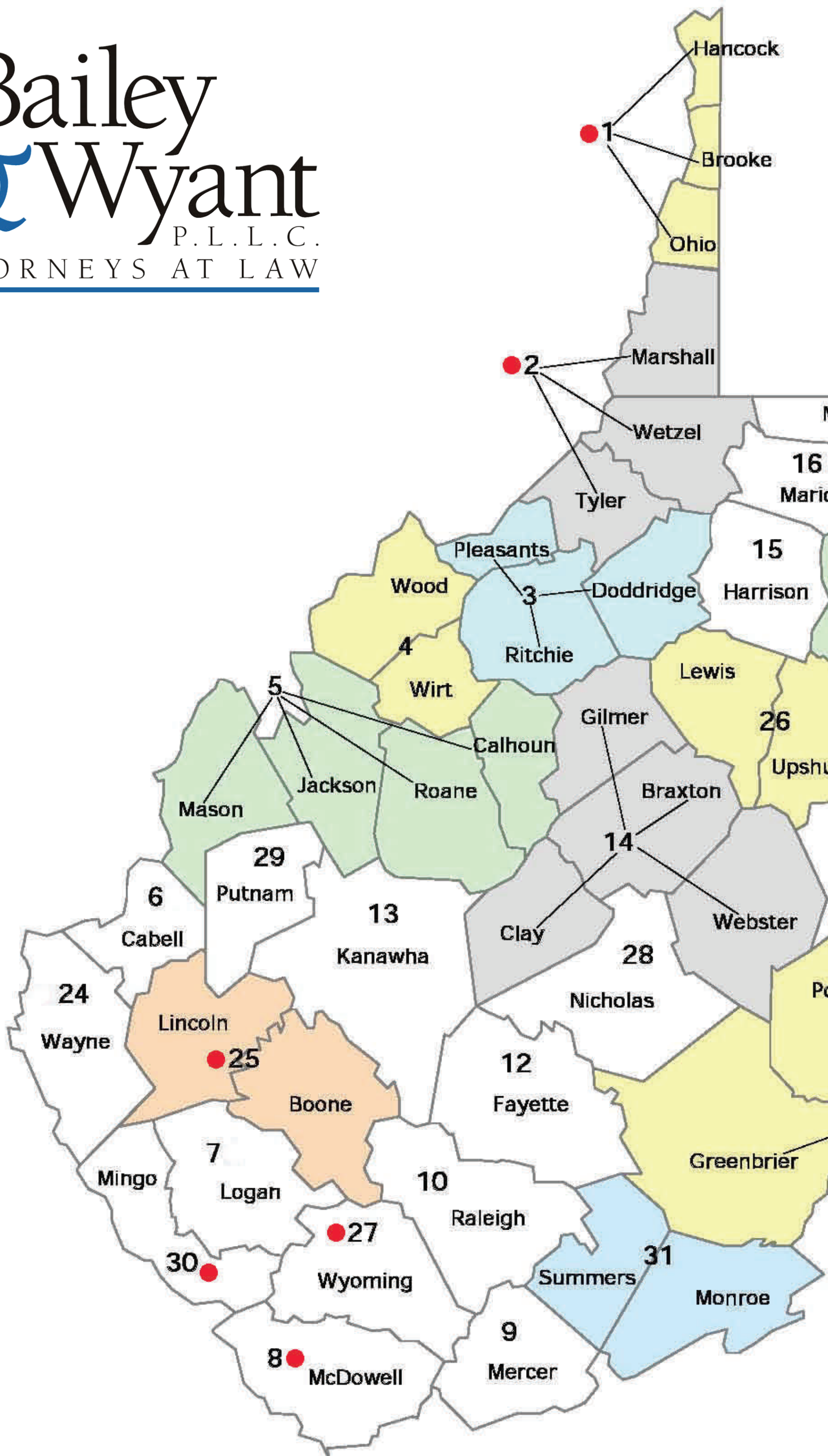
● Circuits with historically pro-plaintiff rulings and verdicts.



I. WEST VIRGINIA TORT LAW

A. The Basic Elements

West Virginia employs a traditional English common-law tort system, with all of the standard rules and principles. Negligence is the failure to exercise ordinary care, and ordinary care is that kind and degree of care or caution which an ordinary prudent and careful person would exercise under the same or similar circumstances. A negligence claim requires a claimant to prove by a preponderance of the evidence that a breach of duty occurred which proximately caused injury to him or her.

Negligence is doing something a reasonably prudent person would not do in the same or similar circumstances, or the failing or refusing to do something a reasonably prudent persons would have done in the same, or similar circumstance. Negligence cannot be presumed; it must be proven.

Contributory negligence means negligence of the plaintiff, which together with negligence of the defendant, proximately caused the accident. Where contributory negligence is charged by a party, it must be proven by a preponderance of the evidence by the party asserting it.

Assumption of risk means that the plaintiff, knowing full well the hazards involved, failed to take precautions to protect himself from those known or reasonably to be expected hazards.

The proximate cause of an event is the negligent act contributing to the accident, without which the accident would not have occurred. The proximate cause of an event is that cause which in actual sequence, unbroken by any independent cause, produces an event, and without which, the event would not have occurred.

B. Comparative Negligence

Under the law of comparative negligence as adopted by West Virginia, a plaintiff is barred from recovery if his or her negligence equals or exceeds 50% of the total negligence of all parties to the accident, which total negligence equals 100%. A plaintiff's recovery is offset by the percentage of negligence attributable to him or her. Thus, if a jury determines that a plaintiff's total damages are $100,000, and further finds that the plaintiff was 20% at fault, then the plaintiff would be entitled to recover only 80%, or $80,000.

C. Agency

An agent is one who acts on behalf of another and subject to his or her control. With respect to an employee/employer relationship, an employer is liable for all damages proximately caused by the negligence of his agent employee who is acting within the scope of his employment. An employee is acting within the course of his employment when he is engaged in doing, for his employer, either the act directed by the employer or any act which can fairly and reasonably be deemed to be a natural, direct and logical result of the act directed by the employer. If in doing such an act the employee acts negligently, that is negligence within the course of the employment.

In order to recover against a tortfeasor's employer, the plaintiff has the burden of proving by preponderance of the evidence that the tortfeasor was the employee of the employer, that the employee tortfeasor was negligent while acting within the scope of his employment, and that this negligence proximately caused damage to the plaintiff.

Under West Virginia law, a corporation acts by and through its officers, agent, and employees. If an officer, agent or employee of a defendant corporation is found negligent in the performance of his or her duties, then any such negligence is attributable to the corporation and considered negligence on the part of the corporation, including the failure to comply with applicable automobile and road safety laws.

D. Independent Contractor Defense

If a tortfeasor was acting as an independent contractor, then an employer has no responsibility for the tortfeasor's acts. Whether or not a tortfeasor is an independent contractor or agent depends on whether the employer controlled, or had the right to control, the work of the tortfeasor. Control in this sense means the right to determine where and in what manner the work would be done. It does not matter that the employer never actually exercised control over the tortfeasor, as long as the employer reserved to itself the right to do so.

E. Joint Enterprise

When two or more persons undertake an activity involving an automobile for a common purpose, with the common right to control the use of the vehicle, then each is liable for any negligence of the other occupants of the vehicle that is committed during the operation of the motor vehicle. Therefore, the negligence of one of the occupants of the vehicle is imputable to the other occupants of the vehicle if there was a common right to control the vehicle by the other occupants of the vehicle.

However, a passenger in a motor vehicle is not responsible for any negligent acts of the driver of the vehicle by the mere fact the driver and passenger were riding together to the same destination for a common purpose, when the passenger had no voice in directing and controlling the operation of the motor vehicle.

F. Joint Venture

A "joint venture" is an association of two or more persons to carry out a single business enterprise for profit. To constitute a joint venture, each party must contribute something that promotes the enterprise. This can be property, money, efforts, skill, knowledge or anything else which has value and "promotes" the common undertaking. The contributions of the respective parties need not be equal or of the same character. Where a joint venture exists, each joint venturer is liable for the negligence of his or her co-venturers committed within the scope of the enterprise.

G. Substantial Assistance and Encouragement by Passenger

A guest passenger may be held liable for the consequences of the driver's negligent operation of his motor vehicle, where the guest directs or encourages

VI. COVERAGE PRINCIPLES

(1) An insurer's duty to defend is greater than its duty to indemnify. If part of the claims against an insured fall within the coverage of the applicable liability insurance policy and part do not, the insurer must defend all claims, although it might eventually be required to pay only some. Included in the consideration of whether an insurer has a duty to defend is whether the allegations in the complaint are reasonably susceptible of an interpretation that the claim may be covered by the terms of the insurance policy; there is no requirement that the facts alleged in the complaint specifically and unequivocally make out a claim within the coverage under the insurance policy.

(2) Where provisions of an insurance policy contract are clear and unambiguous, they are not subject to judicial construction or interpretation, and full effect will be given to the plain meaning intended. Ambiguities in an insurance policy are construed against the insurer. If language in an insurance policy is ambiguous, then the doctrine of "reasonable expectations" applies, which holds that objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of policy provisions would have negated those expectations.

(3) Exclusionary language contained in an insurance policy is strictly construed against an insurer in order that the purpose of providing indemnity not be defeated. When an insurance company seeks to avoid liability through the operation of an exclusion, the insurance company has the burden of proving the exclusion applies to the facts in the case. When an insurance policy exclusion applies, a liability insurer must look beyond the bare allegations contained in the third party's pleadings and conduct a reasonable inquiry into the facts in order to ascertain whether the claims asserted may come within the scope of the coverage.

(4) An insurer can only deny coverage under an "intentional acts" exclusion if the policyholder (1) committed an intentional act; and (2) expected or intended the specific resulting damage. When an intentional acts exclusion uses language to the effect that insurance coverage is voided when the loss was "expected or intended by the insured," courts must employ a subjective rather than objective standard for determining the policyholder's intent.

(5) An underinsured motorist carrier occupies the position of an excess or additional insurer in regard to the tortfeasor's liability carrier, which is deemed to have primary coverage. Consequently, the tortfeasor's liability carrier, having primary coverage, should ordinarily control litigation on behalf of tortfeasor insured. However, the primary insurance carrier has a duty to act in good faith with respect to the excess or additional insurance carrier when defending claim on behalf of a primary insurance carrier's insured. If an excess carrier can demonstrate that the primary insurance carrier is defending claim in bad faith manner, the underinsured motorist carrier may petition the court to allow it to assume primary control of defense.

Court noted a previous decision where it held that no right of subrogation can arise in favor of an insurer against its own insured since by definition subrogation arises only with respect to rights of the insured against third persons to whom the insurer owes no duty. The Court then noted that its previous decision suggested that a different outcome might be reached if an insurer were to have policy language that clearly created a contractual right to "reimbursement" of medical payments it had advanced to its insured to the extent such medical payments were compensated by a settlement with or judgment against a tortfeasor whom it also insured. Thus, with its previous opinion as guidance on the issue, the Court answered the certified question affirmatively.

Hicks v. Jones, 217 W. Va. 107, 617 S.E.2d 457 (2005)

In this case, the Court addressed the meaning of the phrase "fair and equitable settlement" as stated in the Unfair Trade Practices Act at West Virginia Code § 33-11-4(9)(f). It was held that a fair and equitable settlement was one that is made by the insurer impartially, honestly, and free from prejudice, self-interest or other improper influence. Moreover, the Court went on to state that such a settlement implies a disposition of a claim for an element of damages that has a basis in evidence and in reason, and achieves a fitting and right balance of considerations that is free from favoritism, and is fair and equal to all concerned.

Glen Falls Ins. Co. v. Smith, 217 W. Va. 213, 617 S.E.2d 760 (2005)

Based on a prior decision, the Court held that when a homeowners' or automobile policy does not otherwise define the phrase "resident of your household," that phrase means a person who dwells, though not necessarily under a common roof, with other individuals who are named insureds in a manner and for a sufficient length of time so that they could be considered to be a family living together. The factors to be considered in determining whether that standard has been met include, but are not limited to, the intent of the parties, the formality of the relationship between the person in question and the other members of the named insureds' household, the permanence or transient nature of that person's residence therein, the absence or existence of another place of lodging for that person, and the age and self-sufficiency of that person.

Satterfield v. Erie Insurance Property and Casualty, 217 W. Va. 474. 618 S.E.2d 483 (2005)

The Court determined that where an insured who holds more than one automobile insurance policy with the same insurer acquires an additional vehicle, the named inclusion of the additional vehicle on one insurance policy does not operate to remove coverage extended by the "newly acquired auto clause" in a separate policy, barring language that expressly terminates coverage in such circumstances or requires the insured to make an election as to the specific policy under which coverage is sought.

the negligent act, or personally co-operates therein. Ratification of the negligent conduct of the driver by a guest may be equivalent to command, and co-operation may be inferred from acquiescence where there is power to restrain.

II. DAMAGES

A. Overview of Damages

It is the purpose of the law to compensate a person who has sustained injuries through the fault of another, as fully and as completely as it is possible in dollars and cents to make compensation for such injuries. However, damages which are purely speculative cannot be recovered. It is the uncertainty as to the fact of damages, and not as to the amount of damages, that is to be considered. Where it is certain that the damages resulted, uncertainty as to the amount does not justify the jury in refusing recovery.

If a jury believes from a preponderance of the evidence that a plaintiff is entitled to recover a verdict, then in it has a duty to take into consideration any or all of the following items:

(1) Any and all bodily injuries sustained by the plaintiff and the extent and duration of such bodily injuries;

(2) Any and all physical pain the plaintiff has suffered in the past;

(3) Any and all physical pain the plaintiff, with reasonable certainty, shall suffer in the future because of said injuries, and the probable duration or permanency of such pain;

(4) Any and all suffering or mental anguish the plaintiff has suffered in the past;

(5) Any and all suffering or mental anguish the plaintiff, with reasonable certainty, shall suffer in the future because of any such injuries, and the probable duration or permanency of such suffering or mental anguish;

(6) Any and all effects the bodily injuries, pain, inconvenience or suffering have had in the past upon plaintiffs health and plaintiffs ability to enjoy life, the extent of such losses of his health and ability to enjoy life, and any and all losses of health and ability to enjoy life, which with reasonable certainty plaintiff will suffer in the future because of the effects of said injuries;

(7) The just, reasonable, and necessary doctor, hospital, and medical expenses incurred by plaintiff as a result of his injuries;

(8) The reasonable and necessary doctor, hospital, and medical expenses plaintiff shall with reasonable certainty incur in the future as a result of his injuries;

(9) Any and all past losses of earnings or caning capacity which plaintiff has lost in the past by reason of being unable to work as a result of said injuries;

(10) Any and all loss of earnings or earning capacity and fringe benefits which plaintiff shall with reasonable certainty lose in the future by reason of being unable to work as a result of said injuries, and the probable extent and duration of any such future loss of earnings or earning capacity;

(11) The reasonable value of household services, if any, provided to or for plaintiff by reason of plaintiffs injuries, and the reasonable value of household services that with reasonable certainty shall be necessary for plaintiff in the future and the probable extent and duration of any such future household services or expenses;

(12) In considering the duration or permanency of any such injuries, pain, suffering, or losses, a jury may take into consideration the plaintiffs probable life expectancy.

Compensation for pain, suffering, loss of enjoyment of life, and loss of consortium are general items of damages. There is no rule or measure upon which these damages can be based. The amount of compensation to be awarded for such injuries is left, by law, to the sound discretion of the jury as to what is fair and just.

Loss of the enjoyment of life, or of the ability to enjoy life, refers to how the injury has affected the plaintiff's ability to perform and enjoy the ordinary functions of life. The degree of such an injury is measured by ascertaining how the injury has deprived the plaintiff of his or her customary activities as a whole person. Accordingly, in assessing damages for loss of the ability to enjoy life, a jury considers the customary activities of the plaintiff prior to the incident giving rise to the claim, and how, if at all, the injuries he or she suffered affects his or her ability to perform and enjoy these activities.

Consortium is defined generally as the society, companionship, comfort, guidance, kindly offices and advice existing between a husband and a wife or between a parent and a child. If a jury determines from the evidence that there has been an interference with the consortium rights of a plaintiff's husband, wife or child, damages may be assessed against the defendant.

In determining the damage suffered by a plaintiff, a jury may consider as an element of damages any aggravation of any preexisting condition which proximately results from the incident. Even if the jury believes that the plaintiff was afflicted with some condition at the time of the injury from which he or she might have a predisposition, but was otherwise in good health, and the injuries received in the collision developed or aggravated this condition and predisposition, then the defendant is liable for the plaintiff's condition or his or her aggravation.

The extent or seriousness of a permanent injury is measured by ascertaining how the injury has deprived a plaintiff of his customary activities and has reduced the capacity of the plaintiff to function as a whole person.

In determining the loss of earning capacity, it is unnecessary that the jury find that the plaintiff would actually have worked at a particular job or have earned a certain sum of money. All the plaintiff is required to prove is that he could have performed a particular job or work but is unable to do so now, and will with reasonable certainty be unable to do such work in the future.

The jury is to reduce the claim of plaintiff for future loss of earnings and future fringe benefits, if any, to present dollar value. However, since there is no definite measure to use to determine indefinite damages, such as pain, suffering, loss of

Dairyland Ins. Co. v. West Virginia National Auto Ins. Co., 218 W. Va. 252, 624 S.E.2d 599 (2005)

It was determined by the Court that if an insurance company chooses to issue a new policy of automobile liability insurance and the insured fails to pay the initial premium or otherwise provide consideration for the new policy, the insurer may cancel the policy but must provide the insured with at least 10 days notice of the cancellation as required by West Virginia Code § 33-6A-1(e). Where there has been an invalid cancellation of an automobile liability policy, the policy remains in effect until the end of its term or until a valid cancellation notice is provided to the insured, whichever occurs first.

Newark Ins. Co. v. Brown, 218 W. Va. 346, 624 S.E.2d 783 (2005)

The Court found that West Virginia Code § 33-6-31(b), which requires an automobile liability policy to provide an option of uninsured and underinsured motorist coverage, does not require an offer of such coverage when an insured purchases umbrella liability policy. However, West Virginia Code § 33-6-31f(a), which was enacted after West Virginia Code § 33-6-31(b) in 2001, does require an offer of such coverage by an insurer issuing an excess or umbrella policy covering automobile liability. Because West Virginia Code § 33-6-31f(a) is more specific in nature, it prevails over the more general provision of West Virginia Code § 33-6-31(b). Thus, as of July 2001, which was the effective date of West Virginia Code § 33-6-31f(a), insurers who issue (or issued) excess or umbrella policies covering automobile liability must provide the insured the option of purchasing uninsured and underinsured motorist coverage.

Ferrell v. Nationwide Mutual Ins. Co., 217 W. Va. 243, 617 S.E.2d 790 (2005)

In this case, the Court was asked to answer the following certified question: "May an insurance company seek reimbursement of medical expense payments made to an insured, where (a) the insurance policy allows the insurance company to seek "reimbursement" of those medical expense payments from the insured out of any recovery obtained by the insured from a third party; (b) the proceeds of the recovery from the third party duplicate the insurance company's medical expense payments to the insured; and © the insurance company is the liability insurer of the third party"?

Before answering this certified question, the Court summarized West Virginia's position regarding subrogation clauses in insurance policies. The Court stated that, generally speaking, this state's public policy permits insurers to pursue subrogation of medical payments from their own insureds. The Court went on to say that insurers can, in fact, pursue subrogation against an insured who receives benefits under the policy if the insured successfully recovers from a tortfeasor, although the insurer must reimburse the insured its share of the attorney fees and costs of obtaining the recovery from the tortfeasor.

A different result occurs, however, when an insurer seeks subrogation of medical expense payments from a plaintiff-insured when both the plaintiff-insured and the tortfeasor are insured by the same insurance company. In this instance, the

for the insolvent insurer's policy once the company was declared insolvent, then the Guaranty Association was responsible for providing the primary liability insurance coverage for the defendant's negligence. In short, NUFIC argued that it provided only excess insurance coverage to HRDF, and that its responsibility under the policy would only be triggered when the Guaranty Association had exhausted its obligation to provide primary coverage.

The Guaranty Association argued that the NUFIC policy explicitly defines the coverage provided as "primary" for any covered auto owned by the insured. The policy stated, under the title "other insurance":

For any covered "auto" you own, this Coverage Form provides primary insurance. For any covered "auto" you don't own, the insurance provided by this Coverage Form is excess over any other collectible insurance.

The policy defined HRDF as an additional insured. The Guaranty Association therefore asserted that because HRDF owned the auto involved in the accident, the coverage under the NUFIC policy was primary liability coverage by the policy's own terms and conditions. The Guaranty Association also noted that the language of the NUFIC policy was ambiguous, and should be construed against NUFIC.

In an order dated February 15, 2005, the circuit court granted summary judgment in favor of the Guaranty Association. The circuit court rejected NUFIC's argument that its policy was nothing more than an excess liability insurance policy that was intended to provide coverage only after primary insurer had fulfilled its obligations. The circuit court concluded that the terms of the NUFIC policy:

> . . . identify it as a primary insurer. . . . Thus, the plain language of the policy is such that it provides primary insurance to automobiles owned and operated by the insureds, [HRDF and the defendant].

In finding for the Guaranty Association, the Supreme Court held:

When an insurance company (a) issues a primary liability insurance policy; and (b) has contracted for and received a premium for a risk as though it were a primary insurer; but © the insurance company has become a secondary insurer by operation of an "other insurance" clause in the policy and the existence of another primary insurance carrier, then if that other insurance carrier is declared insolvent, the insurance company is responsible for coverage of the loss as though it were the sole primary liability insurer.

Jenkins v. State Farm Automobile Ins. Co., 219 W. Va. 190, 632 S.E.2d 346 (2006) (per curiam)

The Court found that underinsured motorist ("UIM") coverage under a policy issued to the insured's spouse did not apply while the insured was driving his mother's vehicle. Even though the spouse's policy allowed for UIM benefits up to the highest limit of liability of any applicable policy, it unambiguously made UIM coverage inapplicable for injury to the insured while occupying or otherwise using a vehicle owned by a relative if the vehicle was insured for UIM coverage under a policy issued by the same insurer.

enjoyment of life, and loss of consortium, a jury is not to make a similar reduction for those general damages.

In deliberating the present value of the future income and benefits of the plaintiff, the jury should use that rate of interest which, in the jury's considered judgment, is reasonable, just, and right under the circumstances, taking into consideration the evidence presented, the jury's knowledge of the prevailing interest rates, and what rate of interest could fairly be expected from safe investments that a person of ordinary prudence, but without particular financial experience or skill, could earn in the area.

The fact that the actual cost of future medical care for plaintiff could not be stated to an absolute certainty does not defeat his right to recover for such fixture medical expenses. It is sufficient that the projected expenses were not speculative or conjectural, are reasonably probable, and were indicated within an approximate range.

B. Wrongful Death Damages

In awarding damages for wrongful death, it is the jury's duty to award, pursuant to West Virginia Code § 55- 7-6(c)(1), monetary damages for the following:

(1) The sorrow and mental anguish suffered by the decedent's family members and his or her other beneficiaries;

(2) The loss of solace, which may include society, companionship, comfort guidance, kindly offices and advice, which has been suffered by the decedent's family members and other beneficiaries as a result of his death;

(3) Compensation for the reasonably expected loss of (i) income of the decedent, and (ii) services, protection, care and assistance provided by the decedent;

(4) Expenses for the care, treatment and hospitalization of decedent incident to the injury which resulted in his or her death; and

(5) Reasonable funeral expenses.

The "reasonably expected loss of income" is the total amount, properly discounted to present value that a decedent would reasonably have been expected to earn had he or she lived out a normal life span. It is not merely the amount of his or her future earnings which his family and other beneficiaries might reasonably have expected to receive from had he lived out a normal life span.

C. Punitive Damages

A jury may award punitive damages against a defendant as punishment for willfulness, wantonness, malice or other like aggravation of the wrong done to the plaintiff. Punitive damages are something in addition to full compensation not given as the plaintiffs due, but given rather with a view to the enormity of the offense to punish the defendants and make an example of them so that others will be deterred from committing similar offenses.

The law awards compensatory damages when the unlawful act is done without intent to do wrong or where there is no malice or where the offense is not

oppressively or recklessly committed, while punitive damages are awarded where the wrongful act is done with a bad motive, or in a manner so wanton or reckless as to manifest a willful disregard of the rights of others.

In awarding punitive damages, a jury may consider the following factors:

(1) The harm that is likely to occur from the defendant's conduct as well as to the harm that actually has occurred. If defendant's actions caused or would likely cause in a similar situation only slight harm, the damages should be relatively small. If the harm is grievous, the damages should be greater;

(2) Whether defendant’s conduct was reprehensible, and in doing so should take into account how long defendant continued in his actions, whether defendant was aware that its actions were causing or were likely to cause harm, whether defendant attempted to conceal or cover up his actions or the harm caused by such actions, whether/how often defendant engaged in similar conduct in the past;

(3) Whether defendant profited from' his wrongful conduct, and if you find defendant did profit from his conduct you may remove the profit and your award should be in excess of the profit, so that the award discourages future bad acts by defendant;

(4) As a matter of fundamental fairness, punitive damages should bear a reasonable relationship to compensatory damages;

(5) In determining the amount of punitive damages, the financial position of defendant is relevant.

III. PROPERTY DAMAGE CLAIMS

A. Personal Property

Generally, the proper measure of damages for loss or destruction of personal property, other than that which has a peculiar value to its owner, such as an heirloom or a particular portrait, is the fair market value of the property at time of its loss or destruction.

The proper measure of damages for injury to personal property is the difference between its fair market value immediately before the damage and its fair market value immediately after the damage, plus necessary reasonable expenses incurred by the owner in connection with the damage. However, when damaged personal property can be restored to is previous condition, the measure of damages should be the amount required to restore such property to its previous condition. Thus, when personal property is injured, the owner may recover costs of repairing it, plus his expenses stemming from the injury, including loss of use during repair. If the injury cannot be repaired or the cost of repair would exceed property's market value, then the owner may recover its lost value, plus his expenses stemming from the injury, including loss of use during time he has been deprived of his property. Testimony regarding the value of articles of personal property to a plaintiff and of the price the plaintiff paid for such personal property is inadmissible to show market value of such personal property.

(6) Reserves documents determined to be opinion work product are generally protected from disclosure under the provisions of Rule 26(b)(3) of the West Virginia Rules of Civil Procedure unless the party seeking discovery demonstrates compelling need for the materials, which shall include proof that the opinion materials qualify for a recognized exclusion from application of the work product doctrine.

With regard to the disclosures at issue, the Court held that there was no basis in the limited record to conclude that the reserves were set for reasons other than the ordinary course of business, and that Erie did not prove that the principal reason for setting the reserves was anticipation of litigation.

Gauze v. Reed, 219 W. Va. 381, 633 S.E.2d 326 (W.Va. 2006)

The underlying dispute arose from a single-car accident that occurred on September 4, 2001. The complaint filed by the plaintiff alleged that the defendant negligently operated her vehicle in which he was riding as a passenger.

The vehicle involved in the accident was owned by the Human Resource Development Foundation (HRDF), a non-profit agency and an administrator of a state-funded program that provided lower income applicants with transportation for job purposes. The vehicle was leased to the defendant under a lease-to-own arrangement. In the lease agreement, HRDF acknowledged sole ownership of the vehicle and agreed to provide insurance coverage on the vehicle.

The insurance company that provided coverage was declared insolvent shortly after the accident, and liquidation was ordered by the Circuit Court of Cook County, Illinois. As a result of the insolvency order, the appellee West Virginia Insurance Guaranty Association (Guaranty Association) stepped into the insolvent insurer’s place and assumed the defense of the defendant.

As a non-profit agency, HRDF also qualified for insurance coverage provided through the State of West Virginia by the Board of Risk and Insurance Management, as authorized by West Virginia Code § 29-12-5. The Board of Risk and Insurance Management purchased automobile liability insurance for vehicles owned by HRDF, including the vehicle leased to Ms. Reed from National Union Fire Insurance Company (“NUFIC”).

The statutes which create the Guaranty Association require that a plaintiff exhaust all potential solvent sources of insurance coverage before recovering from it. This provision is commonly referred to as the non-duplication provision of the Insurance Guaranty Association Act.

Following the insolvency of the liability insurer, NUFIC’s contended that its policy did not provide liability insurance coverage for the plaintiff's claim, as its policy was an “excess” insurance policy rather than a primary liability insurance policy. NUFIC pointed to “other insurance” language contained in the certificate of liability insurance indicating that if HRDF “has other primary insurance” from another source, then there was no coverage provided by NUFIC's policy except to the extent that the “amount of loss exceeds the limit of liability” of the other primary insurance policy. NUFIC therefore argued that because HRDF had purchased other primary insurance, and the Guaranty Association had assumed responsibility

An appeal must be filed:

(1) Within 30 days after the Commissioner's order (or order denying a rehearing) has been mailed or delivered to the persons entitled to receive it.

(2) By written petition to the Kanawha County Circuit Court with a copy to the Commissioner who, in turn, must transmit the record of the proceedings to the clerk of that court.

The petitioner must give written notice to the Commissioner of the time and place the judge has set for a hearing at least 15 days prior to the hearing.

The judge, without a jury, is to hear and determine the matter upon the record of the proceedings before the Commissioner and enter an order revising or reversing the order of the Commissioner for further proceedings.

If good cause is shown, the Judge may permit additional evidence to be introduced.

Pending such appeal, the order of the Commissioner shall be in full force and effect unless stayed until final determination by the Commissioner or the court or judge before whom the appeal is pending.

The State Supreme Court of Appeals may review the circuit court's judgment on appeal in the same manner as other civil cases to which the State is a party.

C. Insurance-Related Case Law

Below is a brief summary of significant insurance-related decisions of the Supreme Court of Appeals of West Virginia over the past few years.

State ex rel. Erie Insurance Property & Casualty Co. v. Mazzone, et al., 220 W.Va. 525, 648 S.E.2d 31 (2007)

In this case, the Supreme Court denied a writ of prohibition sought by insurer in a third-party bad faith action to prevent enforcement of an order requiring disclosure of relevant reserves information to the plaintiff below. In short, the issue was whether case reserves information is privileged from disclosure. In the following enumerated syllabus points, the Court held as follows:

(4) When individual case reserves information is set by an attorney or by a non-lawyer representative with the primary intent of preparing for litigation, then the individual case reserves information is subject to protection from discovery as opinion work product pursuant to Rule 26(b)(3) of the West Virginia Rules of Civil Procedure.

(5) For the purposes of Rule 26(b)(3) of the West Virginia Rules of Civil Procedure, aggregate reserves documents compiled for specific litigation either by a lawyer or by a non-lawyer representative are opinion work product and merit greater protection from discovery. However, aggregate reserves documents not developed primarily in anticipation of specific litigation but produced for general business purposes are not protected by the work product rule.

If the owner of a vehicle which is damaged and subsequently repaired can show diminution in value based upon structural damage after repair, then recovery is permitted for that diminution in addition to the cost of repair, but total shall not exceed market value of vehicle before it was damaged. In order to recover for diminution in value, in addition to costs of repairing a damaged vehicle, there must be actual proof that value is diminished following repair, diminution in value must be due to structural damage, and vehicle must have had significant value prior to accident.

B. Realty

When realty is injured the owner may recover the cost of repairing it, plus his expenses stemming from the injury, including loss of use during the repair period. If the injury cannot be repaired or the cost of repair would exceed the property's market value, then the owner may recover its lost value, plus his expenses stemming from the injury including loss of use during the time he has been deprived of his property. Annoyance and inconvenience can be considered as elements of proof in measuring damages for loss of use of real property.

C. Adjusting Property Damage Claims

In West Virginia, it is imperative that denials of first-party claims, particularly those involving property damage, are effectuated with caution. When an insurer wrongfully withholds or unreasonably delays payment of an insured's claim, the insurer is liable for all foreseeable, consequential damages naturally flowing from the delay. When a policyholder "substantially prevails" in a property damage suit against an insurer, the policyholder is entitled to damages for net economic loss caused by the delay in settlement, as well as an award for aggravation and inconvenience.

The question of whether an insured has "substantially prevailed" against his or her insurance company on a property damage claim is determined by the status of negotiations between the insured and the insurer prior to the institution of the law suit. Where the insurance company has offered an amount materially below the damage estimates submitted by the insured, and the jury awards the insured an amount approximating the insured's damages, the insured has substantially prevailed.

In addition, an insured "substantially prevails" in a property damage action against his or her insurer when the action is settled for an amount equal to or approximating the amount claimed by the insured immediately prior to the commencement of the action, as well as when the action is concluded by a jury verdict for such an amount. In either of these situations the insured is entitled to recover reasonable attorney's fees from his or her insurer, as long as the attorney's services were necessary to obtain payment of the insurance proceeds.

When a policyholder substantially prevails on a first-party insurance claim against an insurer and becomes entitled to a reasonable attorney's fee, the amount of the attorney's fee is determined by the circuit judge and not by a jury. A reasonable contingent attorney's fee is presumed to be one-third of the recovery, unless the face value of the policy is extremely small or enormously large—under $20,000.00

or over $1,000,000.00. It is up to the circuit court to make an inquiry into what a reasonable fee might be. Whatever the award, that amount is unliquidated and unsettled until the circuit court issues its ruling. Only after the circuit court approves the policyholder's attorney's fee does the amount become liquidated and established. As such, prejudgment interest is not available.

A circuit court may shift a policyholder's attorney's reasonable litigation expenses to the insurance carrier as well. However, in most cases, those litigation costs are not out-of-pocket expenditures because under a contingent fee agreement, the policyholder does not become responsible for these costs until after the insurance carrier pays the verdict or settlement. Accordingly, as with attorney's fees, a policyholder usually may not recover prejudgment interest on litigation expenses incurred by his attorney.

IV. JOINT AND SEVERAL LIABILITY

In 2005, the State Legislature enacted legislation changing the law of joint and several liability in West Virginia. The new law, codified at West Virginia Code § 55 -7-24, applies to causes of action that accrued on or after July 1, 2005. Under the new law, if any defendant is found to be 30% or less at fault, then such defendant's liability to the plaintiff will be several and not joint, which means that the defendant is only liable to the plaintiff for the damages attributable to the defendant. As a simplistic example, if a particular defendant is found to be twenty percent 20% at fault and the damages are determined to be $10,000, then that defendant is only liable to the plaintiff in the amount of $2,000 (subject to reallocation as discussed below).

The exceptions to the new joint and several liability rule apply to those defendants who are determined by a jury to have:

(1) Acted with intent to inflict injury or damage;

(2) Acted in concert with other defendants as part of a common plan or design resulting in harm;

(3) Negligently or willfully caused the unlawful emission or disposal or spillage of a toxic or hazardous substance; or

(4) Manufactured or sold a defective product in which strict liability is imposed.

If a claimant is unable through good faith efforts to collect from a liable defendant, the claimant may, not later than six months after the judgment becomes final through lapse of time for appeal or through exhaustion of appeal (whichever occurs later), request reallocation of any uncollected amount among the other parties to the suit. It is for the Court (not a jury) to decide whether all or a part of a defendant's proportionate share is uncollectible and to reallocate the uncollected amount among the other parties based upon the percentages of fault at issue, which includes, if any, the plaintiff's percentage of fault.

A defendant subject to reallocation still maintains any rights and obligations of indemnity and contribution which the defendant may maintain or owe as against any other party. An exception to reallocation is triggered when a defendant's percentage of fault is equal to or less than the plaintiff's percentage of fault or the

8. Penalties, Restitution & Judicial Review

If the Commissioner determines at the hearing that a respondent has committed an unfair claim settlement practice, the Commissioner must:

(1) Enter an Order directing the respondent to cease and desist the practice.

(2) The Commissioner may also:

(a) Assess penalties as prescribed by West Virginia Code § 33-11-6 (a) through (e) may be imposed, including:

(i) A fine up to $1,000 for each UTPA violation to an aggregate of $10,000 if the violation was not intentional and not conducted with such frequency so as to constitute a general business practice.

(ii) A fine up to $5,000 for each UTPA violation to an aggregate of $100,000 in a six-month period if the insurer knew or should have known it was a UTPA violation.

(iii) A fine up to $10,000 for each UTPA violation without an aggregate limit if the Commissioner finds the act was intentional, but not conducted with such frequency so as to constitute a general business practice.

(iv) A fine up to $250,000 if the Commissioner finds that a violation occurred with such frequency as to constitute a general business practice. Such a finding of a general business practice must involve substantially similar violations in a number of separate actions.

(v) Revoke or suspend the license of any persons who knew, or reasonably should have known, they were in violation of the UTPA.

(vi) Order restitution to be awarded to the claimant to be paid from the Unfair Claim Settlement Practice Trust Fund established by West Virginia Code § 33-11-4(b).

If the Commissioner determines that the claimant has suffered damages as a result of a general business practice of the respondent or an egregious act that was made by the respondent, regardless of whether the act occurred as a general business practice, the Commissioner may award the claimant actual economic damages and up to $10,000 for non-economic damages. There can no award for attorney fees or punitive damages.

Judicial review is available for any person aggrieved by any act of the Commissioner, which includes the entry of an Order, or by a failure of the Commissioner to act, pursuant to West Virginia Code §§ 33-2-14 and 33-11-6(g).

6. Complaint Hearings

- Shall be held within 90 days from the date a Complaint is filed unless it is continued by agreement of all parties or by the Commissioner for "good cause." "Good cause" includes, but is not limited to, the Commissioner's determination that additional investigation is necessary.
- Shall be assigned a time and place by the Commissioner by notice to the parties at least 10 days in advance of the hearing.
- Shall be conducted in the geographic region of the state where the complainant resides, as determined by the Commissioner.
- May be conducted by telephonic conference call, if all parties concur.
- Shall be conducted pursuant to 114 CSR 13, except for conflicts with this rule.
- Shall determine pre-hearing matters pursuant to 114 CSR 13.4.
- Shall record testimony and evidence stenographically or by mechanical means.
- Shall have findings made by the Commissioner of whether or not the respondent committed an unfair claim settlement practice. If an unfair claim settlement practice is found, the Commissioner is required to determine:

  (1) Whether the violation was intentional;

  (2) Whether the violation was the result of an egregious act; and

  (3) Whether the violation was committed with such frequency as to constitute a general business; and

  (4) Whether a hearing is necessary brought pursuant to an administrative proceeding initiated by the Commissioner.

- May be continued or adjourned from day to day or to a later date to hear evidence related to the required determinations that the Commissioner must make.

7. Commissioner's Authority

Nothing in the rule limits the authority of the Commissioner to conduct an investigation of, or to take action against, a respondent whom the Commissioner has reason to believe has:

(1) Intentionally committed an unfair claim settlement practice;

(2) Committed an unfair settlement practice with such frequency as to constitute a general business practice; or

(3) Consistently uses the 60-day period to resolve or settle a third-party claim.

percentage of fault of the defendant is less than 10%. In such a case, the defendant's obligation to the plaintiff may not be increased by way of reallocation. It should be noted, however, that when the exception is applied to a particular defendant such that said defendant's obligation to the plaintiff is not increased, that portion of the judgment which is not applied to the exempt defendant shall be reallocated to the other parties who are not exempt according to their respective percentage of fault.

V. UNFAIR TRADE PRACTICES

A. Statutory Law

Chapter 33 of the West Virginia Code provides the primary framework for regulation of the insurance industry within the State. The following selected definitions are provided for in Chapter 33 and apply to individuals or entities conducting the business of insurance in West Virginia:

- insurer is every person engaged in the business of making contracts of insurance;
- person includes an individual, company, insurer, association, organization, society, reciprocal, partnership, syndicate, business trust, corporation or any other legal entity;
- a domestic insurer is an insurer formed under the laws of West Virginia;
- a foreign insurer is an insurer formed under the laws of the United States or of another state of the United States;
- an alien insurer is an insurer formed under the laws of a country other than the United States; and
- mutual insurer is an incorporated insurer without permanent capital stock and the governing body of which is elected by the policyholders.

Generally speaking, in West Virginia, the business of insurance is regulated by the Office of the Insurance Commissioner. It has plenary power to promulgate rules and regulations pertaining to the business of insurance, as well as the duties and obligations of insurers in handling claims. The insurance regulations are found in Title 114 of the West Virginia Code of State Rules. Of particular note is Series 65, which provides rules and regulations pertaining to self-insurance pools for political subdivisions. While such arrangements are authorized, they must contain a financial plan, have sufficient capital, and contain a policy agreement. Importantly, the West Virginia Insurance Guaranty Association does not provide coverage for claims made against the pooling entities in the event of default or insolvency.

Over the past two years, the legal landscape of West Virginia insurance law has been significantly altered. The changes are primarily due to the passage of certain legislation in 2005 relating to third-party "unfair trade practices" claims and changes in the law regarding joint and several liability. The information

contained in this section is intended to update the reader on this legislation and the accompanying rules, as well as to report on significant insurance-related decisions of the West Virginia Supreme Court of Appeals from June 2005 to present.

During the 2005 regular session of the West Virginia Legislature, Senate Bill 418 was enacted into law. This legislation, which became effective on July 7, 2005, prohibited "third-party claimants" from bringing a lawsuit against any person for an "unfair claim settlement practice." A "third-party claimant" is defined as any individual, corporation, association, partnership, or any other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity insured under an insurance contract for the claim in question. An "unfair claim settlement practice" means a violation of the provisions of West Virginia Code § 33-11-4(9).

In relation to third-party claims, West Virginia Code § 33-11-4(9) provides that no person shall commit or perform with such frequency as to indicate a general business practice, among other things, any of the following:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(5) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(6) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(7) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(8) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(9) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

- The Commissioner may order further investigation or a hearing.

4. Resolution Without a Hearing

The Commissioner is to close a Complaint and take no further action (except as provided in West Virginia Code § 33-11-4(a)(I) and Rule 5.4) if it is determined that the respondent:

(1) Substantially corrected the circumstances that gave arise to the Complaint within the 60-day period;

(2) Offered to resolve the Complaint in a reasonable manner within 60-day period; or

(3) Gave sufficient information to satisfy the Commissioner that the Complaint lacks merit.

The Commissioner can close a Complaint any time after the 60-day period expires, including during or after a hearing. A claimant has the right to demand a hearing in writing pursuant to West Virginia Code § 33-2-3 on the issue of whether the Commissioner properly decided to close a Complaint. If error is found, the Complaint is re-opened and proceeds as if no closure occurred. Other deadlines applying to a Complaint are tolled until a determination is made after an improper closure hearing.

Despite any closure of a Complaint by the Commissioner under this rule, the Commissioner has the authority to consider evidence related to the factual allegations of the Complaint in determining (in the context of a proceeding other than the one involving the closed claim itself) whether the alleged unfair settlement practice was, when considered in conjunction with other similar violations, part of the general business practice.

5. Determining the Need for a Hearing

After the 60-day period has expired without a resolution of the Complaint or the respondent declares that no further action will be taken to resolve the Complaint within the 60-day period, the Commissioner may conduct an investigation deemed necessary to determine whether the allegations contained within the Complaint are meritorious.

If there is a finding that an unfair claim settlement practice has been committed, the Commissioner also may conduct an investigation to determine whether the violation was committed with such frequency as to constitute a general business practice.

For any Complaint not closed or that has been ordered to be reopened, and the Commissioner makes a preliminary finding that the Complaint has merit, a complete copy of the Complaint and the respondent's response, if any, must be forwarded to the "Office of Consumer Advocacy."

A Complaint is deemed filed on the date on which a written document describing acts that could reasonably be construed as an unfair claim settlement practice is received by the Insurance Commissioner, regardless of whether the document is on the following described form.

A Complaint is to be on a form provided by the Insurance Commissioner (attached hereto) and must state with specificity the following:

(1) The statutory provision, if known, which the person allegedly violated;

(2) The facts and circumstances giving rise to the violation;

(3) The name of any individual or other entity involved in the violation;

(4) The specific policy language that is relevant to the violation, if known; and

(5) Any other information the Commissioner may require.

If a Complaint does not provide sufficient information:

- The Commissioner must contact the claimant within 15 days of its receipt advising of the Complaint's insufficiency.
- The claimant may amend the original Complaint within an additional 15 days from the date of the Commissioner's contact to clarify the Complaint, add and/or delete parties, and make any other necessary changes.
- No further action on the Complaint is to be taken if the claimant does not provide, in the 15 days allowed, the information needed for a sufficiently complete complaint.

If a sufficiently complete Complaint is received:

- The Commissioner must provide to any respondent (by mail or electronic means) a copy of the Complaint within 5 working days of receiving a satisfactory Complaint.
- A respondent must, within 45 days of receiving a Complaint, inform the Commissioner in writing of the status of the negotiations with the claimant unless:

    (1) The Complaint has been resolved and the Commissioner is so advised; or

    (2) The respondent has advised the Commissioner that it does not intend to take any further action to resolve the Complaint.

If a Complaint is unresolved and remains open after the 60-day period, the Commissioner is to conduct an investigation to determine the merits of the allegations. If merit is found:

- The Complaint must be forwarded to the Office of Consumer Advocacy ["OCA"] who may advocate for the claimant's interest at any hearing or during judicial review of any administrative order.

With the passage of Senate Bill 418, a third-party claimant's sole recourse for an unfair claim settlement practice is to bring an administrative complaint with the Insurance Commissioner. The time frame by which a complaint must be submitted is within one year following the actual or implied discovery of the alleged unfair claim settlement practice. Upon a "sufficiently complete administrative complaint," the Commissioner is to provide the person against whom the complaint is filed with written notice of the alleged violation. The complaint will be closed by the Commissioner if the recipient of the notice substantially corrects the circumstances that gave rise to the violation or makes an offer to resolve the complaint in a manner found reasonable by the Commissioner within sixty 60 days of receiving the notice. If the complaint is resolved, the recipient of the notice is to report the resolution to the Commissioner within 15 days of the disposition, but no later than 60 days from the notice's receipt.

If the third-party claim is not resolved within this 60-day period, the Commissioner shall conduct any investigation that he or she considers necessary to determine whether the allegations contained in the complaint are meritorious. Should merit be found by the Commissioner, an administrative hearing may be held to determine if an unfair claim settlement practice has been committed with such frequency as to constitute a general business practice. The hearing is to be held in the geographical region of the state where the complainant resides and must occur within 90 days from the filing of the complaint. However, the hearing may be continued by mutual agreement of the parties or by the Commissioner for good cause.

If the Commissioner finds that an unfair claim settlement practice has been committed, the Commissioner may provide restitution from the Unfair Claims Settlement Practice Trust Fund 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 fell within a general business practice. Restitution may include noneconomic damages, not to exceed $10,000, and actual economic damages. Restitution may not be given for attorney fees and punitive damages.

The Commissioner may also impose a monetary penalty up to $10,000 if the act in question involves an intentional violation of West Virginia Code § 33-11-4(9) and even though it has not been established that the person engaged in a general business practice. If the Commissioner finds that an insurer committed or performed an unfair claim settlement practice with such frequency as to indicate a general business practice, he or she may penalize the insurer up to $250,000. Any finding by the Commissioner that the actions of a company constitute a general business practice may only be based on the existence of substantially similar violations in a number of separate claims or causes of action.

In addition to placing insurers at risk of large penalties, unlimited awards for economic damages, license revocation and the authority of the Insurance Commissioner to independently investigate and act on alleged unfair claims conduct, the new third-party complaint process can result in findings of "egregious acts" or "a general business practice" that potentially may be used at trial in first-party bad faith cases to justify the award of punitive damages. Accordingly,

compliance with the new standards and deadlines for investigating and settling claims should be strictly adhered to and any third-party administrative complaints should be aggressively defended if they cannot otherwise be resolved within the first 60 days of the complaint being filed.

As of January 26, 2007, there were 467 third party administrative complaints filed with the Insurance Commissioner since the effective date of Senate Bill 418 (July 8, 2005). Of the 467 complaints, 169 were resolved in the 60-day "cure" period, 14 were declared to be outside the jurisdiction of the Insurance Commissioner, 29 lacked sufficient information for the matter to continue, and 227 were referred to the Legal Division of the Offices of the Insurance Commissioner for a merit determination. Of the complaints referred to the Insurance Commission's Legal Division, the overwhelming majority have either been found to lack merit or were resolved prior to the occurrence of an administrative hearing.

Victor Mullins, an attorney with Bailey & Wyant, P.L.L.C., was previously employed as Associate Counsel to the Insurance Commissioner. During his employment with the Insurance Commission, Mr. Mullins was significantly involved in the initial setup of the new third party administrative complaint process. The impression that Mr. Mullins came away with was that the parties involved in this process had been provided an excellent opportunity to efficiently resolve meritorious third party UTPA claims. It is also the opinion of Mr. Mullins that the administrative complaint process devised by the Legislature and the Insurance Commission effectively "weeds out" complaints lacking merit. Mr. Mullins further notes that it was the Insurance Commissioner's position to harshly deal with a company that did not appropriately react to a third party complaint in which a violation was ultimately found.

B. Regulatory Law

In April of 2006, two sets of final administrative rules governing provisions of Senate Bill 418 were adopted and approved by the Legislature and incorporated in the West Virginia Code of State Rules. The adoption of these rules caused many substantive and procedural changes in the way insurance companies must adjust or otherwise handle insurance claims.

Highlights of 114 CSR 14-1, et seq. (Unfair Claims Settlement Practices)

- Defines certain practices that constitute unfair methods of competition or unfair or deceptive acts or practices and establish certain minimum standards and methods of settling both first-party and third-party claims.
- Does not prohibit using additional methods above the stated minimums if they do not violate this rule or any other West Virginia statute or rule.
- Applies to all insurance policies and insurance contracts except Workers' Compensation.
- Is not exclusive. Other acts, not specified in the rule, also may constitute unfair claim settlement practices.

Highlights of 114 CSR 76-1, et seq. (Administrative Complaint Process for Third-Party Claimants)

1. Definitions Applicable to the Rule

- "Claimant" means the third-party claimant as defined in 114 CSR 14-2.8.
- "Complaint" means the administrative complaint filed by a third-party claimant pursuant to West Virginia Code § 33-11-4a(b).
- "Egregious Act" means conduct that is either: (1) fraudulent, or (2) 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.
- "Respondent" means a person against whom a complaint is filed with the Commissioner pursuant to West Virginia Code § 33-11-4a(b).
- "Sixty day period" means the 60 days following the respondent's receipt of a Complaint.

2. Representation of Claimants and Respondents

- Claimants who are natural persons (i.e., not created by law) may appear at and represent themselves in any matter before the Insurance Commissioner.
- Partners may represent their partnership with the Insurance Commissioner's permission.
- Corporations only can be represented by an attorney duly licensed or authorized to practice law in the State of West Virginia, although a corporation's employee may testify at a hearing without the presence of counsel.
- No party can be represented in any matter before the Commissioner by a spokesperson, lay representative or any other natural person not admitted or authorized to practice law in the State of West Virginia.
- Any out of state attorney appearing before the Commissioner must have obtained a pro hac vice admission to the West Virginia State Bar and documentation of that permission must be supplied to the Insurance Commissioner before any such attorney files any papers or makes an appearance.

3. Filing of an Administrative Complaint

A written Complaint must be received by the Insurance Commissioner no later than one year after the actual or implied discovery of the alleged unfair claim settlement practice.

10. Other New Investigation & Settlement Standards

- A new provision prohibits insurers from offering incentives or compensation to its employees, agents or contractors based on savings to the insurer as a result of improperly denying the payment of claims.
- A new rule bars an insurer from deducting premiums owed by the insured on one policy from a claim payment made under another policy unless the insured consents.
- An insurer may not ask or require a claimant to submit to a polygraph examination or other truth detection device in connection with the settlement of a claim unless:
  - (1) Authorized under the applicable insurance contract;
  - (2) Authorized under state law; and
  - (3) The claimant gives written consent prior to use of the device.
- Any notice rejecting any element of the claim must contain the identity and the claims processing address of the insurer and the claim number. The notice also must state that the claimant has the option of contacting the Commissioner and include the Commissioner's mailing address, telephone number and website address.
- No claimant can be required to travel unreasonably either to inspect a replacement motor vehicle or to obtain a repair estimate. Reference to "a specific repair shop" is deleted.
- An insurer may furnish to the claimant names of one or more conveniently located motor vehicle repair shops that will perform repairs. However, an insurer may not require a claimant to use a particular repair shop or location to obtain the repair.
- Added to the fifth criteria required of motor vehicle valuation sources other than a valuation manual is that 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."

11. Training and Certification

Within 90 days of April 24, 2006 (effective date of rule), every insurer must adopt and communicate to all of its claims agents written standards regarding the prompt investigation and processing of claims.

- Does not create or recognize, either exclusively or impliedly, any new or different cause of action not otherwise recognized by law.

1. Definitions Applicable to the Rule

Does not change former definitions of "Claimant," "First-Party Claimant," "Person," "Insurer," "Investigation," "Notification of Claim," "Third-Party Claimant," "Settlement of Claims," "Insurance Policy," "Insurance Contract," or "Claim."

- Deletes in the "Claimant" definition any reference to a "designated legal representative, designated member of claimant's immediate family, or any other person named by the insured" who may legally act on his/ her behalf and who so acts without any compensation.
- Adds "Commissioner" to mean West Virginia's Insurance Commissioner.
- Adds "Licensee" to mean any person holding 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. File and Record Documentation

(1) Requires all communications and transactions from or by the insurer to be dated and maintained in the claim file;

(2) Requires the date and substance of all oral communications to be recorded in the claim file; and

(3) Requires a record or copy of all forms sent to claimants to be in the claim file.

3. Representation of Policy Provisions & Benefits

An insurer is barred from requiring a first-party claimant to provide notification or proof of a claim within a specified time, unless it is required by the policy or set by statute or rule.

4. Standards for Acknowledging Pertinent Communications

Each producer or other licensee, in addition to each insurer, must furnish the Commissioner with a complete written response to any inquiry within 15 working days of the date appearing on the inquiry. (The sole exception is responding to the notice of a third-party administrative complaint, per new rules at 114 CSR 76-1, et seq.)

A "complete written response" must address all issues raised by the claimant or the Commissioner and must include copies of any documentation requested.

This rule is not intended to permit delay in responding to Office of the Commissioner in conjunction with a scheduled examination of the insurer's premises.

5. Standards for Prompt Investigation & Fair and Equitable Settlement

Every insurer is required to promptly conduct and diligently pursue a thorough, fair, and objective investigation and may not unreasonable delay resolution by persisting in seeking information that is not reasonably required for or material to the resolution of a claim dispute. (For medical professional liability claims, the Medical Professional Liability Act (MPLA), West Virginia Code § 55-7B-1, et seq., applies.)

An insurer is required to establish investigatory procedures that:

(1) Require an investigation of any claim to commence within 15 working days of receipt of notice of claim;

(2) Require the insurer to notify each first-party claimant (or authorized representative) of all items, statements and forms the insurer reasonably believes to be required of such claimant within 15 working days of receiving notice of the claim;

(3) Deems a claim to have been filed with an insurer unless an agent of the insurer who receives it does not promptly notify the claimant that the agent is not authorized to receive notices of claims; and

(4) Within 10 working days of completing its investigation, an insurer is required to deny the claim in writing or make a written offer, subject to policy limits. (For medical professional liability claims, the MPLA applies.)

6. Offers of Settlement & Prohibition of Unreasonably Low Settlements

An insurer is prohibited from attempting to settle a claim by making a settlement offer that is "unreasonably low." To determine whether an offer is "unreasonably low," the Commissioner shall consider any evidence offered regarding the following factors:

(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 amount of 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.

7. Denial of Claims

(1) An insurer cannot 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; and

(2) A denial must be given to a claimant in writing or, if by means other than a writing, a notation must be recorded in the insurer's claim file.

8. Notice of Necessary Delay in Investigating Claim

If an insurer needs more than thirty 30 calendar days from the date of receipt of a proof of loss from a first-party claimant or a notice of claim from a third-party claimant to determine whether the claim should be accepted or denied, the insurer is required to:

(1) Provide written notification to claimant within 15 working days after the 30-day period expires; and

(2) Provide written notification to the claimant every 45 calendar days thereafter as long as an investigation remains incomplete, giving why the additional time is needed.

If a claim is being investigated as a suspected fraudulent claim, the insurer is not required to disclose any information that could be reasonably expected to alert a claimant to that fact; however, there must be "a reasonable basis supported by specific information" available for review by the Insurance Commissioner that a claimant has fraudulently caused or contributed to the loss before the insurer is relieved of the requirements of this rule.

9. Time Limits

Every insurer must pay any amount finally agreed upon in settlement of all or part of a claim not later than 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.

The rule has been amended to require written notice be given to a first-party claimant in not less than 30 days and to third-party claimants in not less than 60 days before the expiration date of a time limit (statute of limitations or policy or contract time limit) that may affect the rights of a claimant who is neither an attorney nor represented by an attorney. Otherwise, any negotiation for the settlement of a claim with such a claimant is barred.