2017 WL 3012281 (W.D.Wash.) (Expert Report and Affidavit)
United States District Court, W.D. Washington.

Patricia POTTER and William Potter,
v.
AMERICAN FAMILY INSURANCE COMPANY.

No. 3:16-cv-05406-BHS.
March 20, 2017.

(Report or Affidavit of Robert B. Dietz, B.S.)

Name of Expert: Robert B. Dietz
Area of Expertise: Legal & Insurance >> Insurance Claims
Area of Expertise: Legal & Insurance >> Insurance Practices & Standards
Representing: Plaintiff
Jurisdiction: W.D.Wash.

Sok-Khieng Lim, Attorney at Law

PO Box 1657

Tacoma, WA 98401-1657

Dear Ms. Lim

You hired me to review this matter and render opinions on the claims handling, and of claims practices of American Family Mutual Insurance Company (hereafter AMFAM) regarding Ms. Potter's uninsured motorist bodily injury (UM) claim. This report contains my opinions, the basis and reasons for those opinions, as well as the facts and data considered in forming those opinions. I understand that I may be asked to rely on my knowledge, skill, training and experience, and education in the expression of expert opinions in this matter. In offering opinions, I have relied on the type of data and facts which are reasonably relied upon by all experts generally in the area of insurance claims practices. [1] The methodology I use, is to compare the claims practices and the behavior of the insurer in question in a specific case, to recognized and accepted reasonable industry standards and customs that would be expected from an insurer tasked with handling claims. I understand discovery is continuing and several depositions will be taken. I may have other opinions after such review with which to supplement this report.

Qualifications

Past Employment:

Farmers Insurance Exchange (Farmers) June 1987-August 2001.

During my tenure at Farmers, I rose through the ranks from my initial position as a Claims Representative (CR) to a Senior CR. My primary responsibilities were the investigation and complete file handling of liability claims arising from auto, homeowner, and commercial insurance policies. The majority of the liability claims were injury claims that involved Bodily Injury (BI) to third parties, and Uninsured Motorist (UM) and Underinsured Motorist (UIM) injuries to first parties. I was selected to enter the

management training program, as a CMT, which was an acronym for Claims Management Trainee. I was promoted to Branch Claims Supervisor (BCS) on December 16, 1990. I remained a BCS in the Kirkland Branch Claims Office (BCO) until July 1, 1993. As a BCS, my responsibilities included the hiring, training, development, and supervision of claims adjusters in the field of liability and auto physical damage. I also trained and supervised clerical staff responsible for Personal Injury Protection (PIP) and Med Pay benefits of the auto policies, and Med Pay benefits available under homeowner's policies. I was responsible for ensuring corporate policies, and reasonable industry practices and procedures were followed by every employee. I also saw and prepared numerous management reports addressing various issues within the claims operation.

I returned to the Everett BCO, where my initial career began, on July 1, 1993 to work as a Special CR. I worked in this position until October 16, 2000. While I was a Special CR, I handled numerous claims which required thorough and complex investigations to determine if coverage was applicable. I also handled a larger than average volume of claims, consisting of third and first party injury claims. The nature of the injury claims I handled were generally those claims that were more complex, both in terms of coverage issues, and the severity of injuries.

I was promoted to General Adjuster (GA) on October 16, 2000, and worked in the National Liability Claims (NLC) division of claims. I held that position until my resignation on August 17, 2001. As a GA, I handled injury claims which appeared to have a value over one hundred thousand dollars; many were catastrophic in nature. I again handled both BI and UM/UIM claims. My settlement authority was two hundred fifty thousand dollars per claim. During my employment as a Special CR, and as a GA, I was recognized for my outstanding abilities in evaluating injury claims for settlement purposes. This resulted in many claims that were represented or in litigation to be reasonably concluded by agreement. I received consistent high performance rankings, and compensation. I have conducted numerous training sessions or seminars for claims adjusters, including investigation and evaluation of claims, receiving bonus awards and certificates in appreciation.

Current Employment:

Insurance Claims Consulting, Inc. August 2001 -present.

For the past fifteen years I have been engaged nationwide as a consultant and expert witness in the field of insurance, most particularly in claims practices of insurers. I have worked in about thirty states, including Washington, and have analyzed the claims practices of dozens of insurers, including AMFAM. During this time, I have reviewed over 500 claim files, not including class action files. I have been admitted in both State and Federal Courts.

I have for the past fifteen years, after resigning my career from Farmers, continuously engaged in education and study of insurance claim practices, and reasonable industry customs and standards. Peer review continues to be an ongoing part of this endeavor. I subscribe to numerous industry publications that involves the study of claim practices. In addition to the materials reviewed in the cases in which I am engaged, I attend and present at workshops and seminars throughout the country. I am frequently invited to voluntarily present at various CLE seminars throughout the country, including Washington. Some of these presentations are listed on Exhibit 1.

I have been called on by regulators to assist with a Market Conduct Exam. I have testified in Olympia, WA to legislators on insurance matters. I spent a weekend counseling with the lead lawyer under the late Senator, Edward Kennedy, who was investigating health care reform.

Since 1987, I have personally handled thousands of claims files, and I have reviewed and supervised several thousand more. Reviewing and analyzing insurance claims files in relationship to reasonable industry standards or customs as a claims practices expert is similar to the process that was used while I was an employee of FIE, and how most insurers conduct reviews of their files. Such review is also called an audit, or closed file review.

I have studied the policies, procedures, claims manuals and training materials of most of the large insurance companies, and those of smaller ones as well. This includes AMFAM.

Reading statutes, administrative codes, and keeping abreast of case law decisions are the day-to-day responsibility of every insurance claims professional. Therefore, to the extent my opinions intersect somewhat with the law, it is not my intention to render legal opinions. I intend to explain what an insurer's obligations are in relation to the recognized reasonable industry customs or standards. These are largely derived from the Model Unfair Claims Settlement Practices Act, which every state has adopted in some form, including Washington in the WAC 284-30-330. Indeed, every major insurer whose policies and procedures I have reviewed, including AMFAM, have adopted and incorporated the Model Act and the state specific acts as guiding standards of care, and these are recognized as *minimum* standards. Unfortunately, they are not always implemented. Adjusters handling claims must also have a working understanding of relevant case law that may affect the responsibilities of the claims professional. [2] To be sure, my opinions are those of a claims professional and are not legal opinions; I am not a lawyer.

AMFAM has adopted the Model Unfair Claims Settlement Act, as well as each specific states' act as a recognized reasonable standard of care for claims handling for each of the states it operates in.

Beginning with my employment in the insurance industry in 1987 and continuing through the present in my consulting and testifying case work, as well as the seminars I prepare for and attend that discuss claims practices issues and trends, I have specialized experience and training in insurance claims practices, and practices of the insurance industry.

In support of my experience and qualifications relative to insurance industry, I have attached as Exhibit 1 my current CV.

Compensation

My billing rates are: $300/hour consulting; $300/hour testimony. I have received a $2500 retainer on this case.

List of testimony in other cases

A list of testimony for the past five years is attached as Exhibit 2. All but one of the depositions and trial testimony I have provided in the past five years has been a result of being retained by the plaintiff or insured. As indicated on my CV, I am available to review cases for both plaintiff and defense. I do not advertise or have a web page. I do not solicit work. I respond to those who inquire of my services.

Publications

None.

Listing of Material Sent For Review

I was sent the following documents: the pleadings; the AMFM claims file; the AMFAM insurance policy; discovery responses from the parties; the depositions of both Patricia and William Potter with exhibits; and the deposition of Brandee Turner with exhibits.

Other Data Considered

I have also relied on WAC 284-30-330, from which I will footnote, as well as *The Claims Environment,* First Edition 1993, Insurance Institute of America (IIA), authors James Markham, Kevin Quinley, Layne Thompson. This insurance educational

training text is a well-recognized treatise on claims handling and reasonable industry standards and customs. Indeed, this treatise is included in AMFAM Excel training documents, and Dan Kuecher, then a regional claims manager with AMFAM testified [3] that it in fact is a reliable source of reasonable industry standards. Most insurers have a long history of encouraging its employees to take courses offered through the IIA, including AMFAM, and provides financial incentives for those taking courses and obtaining various designations. This included myself

I have read and relied on generally available and instructive insurance literature. Examples include: *Aggressive Good Faith and Successful Claims Handling,* (1 st Edition 1987), author Willis Park Rokes, Insurance Institute of America; *How Insurance Works,* (2 nd Ed. 2002), authors Eric Wining, Barry Smith, Insurance Institute of America; *Liability Claim Practices,* (*1*st Ed. 2001), author James Jones, American Institute for Chartered Property Casualty Underwriters/Insurance Institute of America; The Dark Side of Goal Setting: The Role of Goals In Motivating Unethical Decision Making, authors Maurice Schweitzer, Lisa Ordonez, and Bambi Douma, Academy of Management Proceedings 2002 MOC:BI; Goals Gone Wild: The Side Effects of Over-Prescribing Goal Setting, Harvard Business School, Working Paper 09-083 Copyright2009 by Lisa Ordonez, Maurice Schweitzer, Adam Galinski, Max Bazerman; The Good Faith Claims File, Council on Litigation Management (CLM) June 8, 2011 presentation; A Primer on Good Faith and Bad Faith Issues for Colorado Claims Association annual claims seminar October 2010 by Franklin Patterson and Craig Nuss; Handling UM/UIM Claims in Colorado, by L. Kathleen Chaney, JD, CPCU, GCA (presented to AMFAM employees). Bad Faith: Revisiting an Insurer's Affirmative Duty to Settle, by Charles Miller, September 2016 Issue of Advocate; Bad Faith and Excess Liability-Insurer Conduct on Trial, by Robert Prahl, CPCU, Director of Education American Association of Insurance Services, Wheaton, Ill.; and Slouching to Gomorrah: Adjuster Pay Plans and Bad Faith, By Kevin Quinley, Claims magazine October 2004.

I am familiar with Washington case law, and Washington Pattern Jury Instructions for civil cases, as a claims professional, as it relates to the business of insurance.

I have relied on the Jury Instructions and the Order For Entry of Judgment from the November 2015 trial of Kimberly Carpenter v. American Family Mutual Insurance Company, United States District Court For The District Of Colorado, Case 13-CV-0986-JLK-CBS. This document is instructive to the issues of this case, and my opinions. I was Plaintiff's Claims Practice Expert, and Trial Consulting witness.

I also rely on the testimony from AMFAM employees and corporate designees from cases I have reviewed, including Dan Keucher, Mike Aston, Mark Juneman, Denice Gruebel, Mike Brown, John Haberland, Amelia Klemme, Roger Rhodes, Cary Huffman, Jackie Hansen, Wade Nielsen, Steve Haneman and others. I rely on the trial exhibits that are in the public domain, from the cases I have testified in, as well as other non-protected American Family documents produced in litigation. Over the past fifteen years, I have reviewed over two dozen cases involving allegations of bad faith against American Family. Some of the cases that I draw reference from that involve issues of UM/UIM include:

1. Carpenter v AMFAM. U.S. District Court, District of Colorado. Case 13-cv-01986-REB-CBS. (Trial and Verdict)

2. Tonn v AMFAM. Iowa District Court for Cerro County, Iowa. Case LACV 06679. (Trial and Verdict)

3. Sobieski v AMFAM. Superior Court, Maricopa County, Arizona. Case cv-2010-092264. (Trial and Verdict)

4. Leeds v AMFAM. Pierce County Superior Court, Washington. Case 13-2-114874.

5. Schreib v AMFAM. U.S. District Court, Western District Seattle, WA. Case 2:14-cv-00165-JLR.

6. Muzzio v AMFAM. U.S. District Court, Colorado. Case 15-cv-01810-PAB-MJW.

7. Cox v AMFAM. District Court, Clark County, Nevada. Case A556395.

8. Nagel v AMFAM. District Court, Clark County, Nevada. Case A592263.

9. Paquette v AMFAM. District Court, Clark County, Nevada. Case A603408.

10. Stebbins v AMFAM. District Court, 6th Judicial District, Bannock County, Idaho. Case cv- 10-221-PI.

11. Paschal v AMFAM. U.S. District Court, Western District Seattle, WA. Case 2:14-cv-01640-RSM.

12. Kisselman v AMFAM. Denver District Court. Case 08-cv-2444, Div.7

13. Smit/Morman v AMFAM. Fourth Judicial Circuit, Meade County, SD. Case cv-10-763.

14. Shaw v AMFAM. Seventh Judicial Circuit, SD. Case cv-11-1674.

15. Fast Horse v AMFAM. Seventh Judicial Circuit, Pennington County, SD. Case CV-05-91.

16. Rumnock v AMFAM. District Court, Denver County, CO. Case 11-cv-1387.

17. Neyens v AMFAM. U.S. District Court, Western District, Seattle, WA. Case 2: 12-cv-01038-JLR.

AMFAM has taken my deposition/trial testimony and/or received a written report from me on nearly every case listed above. They would know of the documents they have produced, and that I have reviewed, and which are in my possession.

From my prior forensic work, I have relied on AMFAM documents ordered produced, not subject to confidentiality, and in the public domain. Those corporate documents reviewed and relied upon include its Excel Casualty Development Participant's Guide and Leader's Guide published from the American Family Education Division, American Family Insurance Coporate »sicº Incentive Program (CIP) for the years 2007-2015, CIP quarterly results updates and articles and program guides for the same years, Code of Ethics, Medical Services Referral Guidelines, State Farm auto claim manual excerpts from its Preface and Our Commitment to Our Policyholders that American Family claims handlers adopted in their deposition testimony, American Family Claim Division Corporate Claim Guidelines for Casualty, Physical Damage, Property and Commercial Farm/Ranch Claim Handling implemented Jan. 20, 2003, and Revised through June 2013, the American Family Performance Pay Planning Process Supporting a Performance-Driven Culture stating “American Family works under a ‘pay for performance’ philosophy that combines alignment of individual performance expectations with corporate objectives and rewards employees based on job performance.” The EXCEL for New Claims Managers, disclosed by AMFAM, itemizes Strategic Goals: Customer Satisfaction, Control Severity, Increase Productivity, Improve Employee Satisfaction, Control Expenses.

I have reviewed reports and data measuring severity of claims, and comparing it to the competition, with goals to lower average paid claims to be at or below the competition. This is also found in states' business plans.

I have reviewed the vast training materials, CIP materials, process and procedure documents produced in *Rumnock,* too voluminous to itemize.

I've also reviewed and relied upon American Family internal claims bulletins dating from 1990, 1997, 1998 and November 2006 (disclosed by American Family) in which American Family writes that it “is interested in the welfare of its insureds and claimants. We want to do everything within reason to see that the claimants' immediate economic concerns are addressed...A release or written agreement is neither necessary nor desirable when making a partial payment.”

Internal American Family claims bulletins also characterized certain claim practices as “reprehensible” such as “Keeping the claimant in financial distress to encourage early settlement” and “Delaying settlement to increase investment income.”

I've reviewed and relied upon Corporate Incentive Program materials and documents disclosed by and from American Family even from its own web site in which it links employee bonuses to company profitability. I've reviewed and relied upon internal American Family materials specifying the amount of bonuses paid to claims handlers and supervisors from its Corporate Incentive Program.

Background Opinions

My opinions are those of a claims professional, and are not to be misinterpreted as legal opinions or conclusions. The foundational precepts I discuss in paragraphs that follow lay the foundation and support for my ultimate conclusions on this particular case. [4] I also lay this foundation so as to try and be complete in my disclosure, and not later be limited in my testimony. These foundational precepts are drawn from the nearly thirty years I have experienced in the insurance landscape. They are formed from my education and continuous study of claims handling practices, including daily and weekly subscriptions to industry literature such as Claims Connection; Property/Casualty 360; Claims Journal; Insurance Journal; FC&S Intelligence; and Claims Magazine. I engage in peer review, and I attend and also am invited to present at numerous CLEs across the country. This foundation includes and incorporates studying the manuals, procedures, and testimony from major insurers, such as American Family, Farmers, State Farm, Allstate, Fireman's Fund, Safeco, and Travelers to name a few.

The insurance company is responsible for fulfilling the promises outlined in the insuring agreements of the contract. While it is not my role to discuss state law with respect to the role of the insurance company, every insurer must adopt and implement systems for the prompt investigation and payment of claims. Insurers who fail to both adopt and implement reasonable policies and procedures for claims handling are at greater risk for improper claims practices. Adopting and implementing reasonable policies and procedures is discussed in more detail on the following page, concerning reasonable claims handling standards. The claims professional's duties arise after a reported loss. These are understood to be affirmative duties.

“When a covered loss occurs, the insurance company's obligation under the policy is triggered. The claim function should ensure the prompt, fair and efficient delivery of this promise. “ The Claims Environment, page 6

Insurers must objectively investigate reasons to pay claims, not just reasons that would support denying them. Insurers must show equal consideration, or equal regard to the interests of the insured, accomplish the purpose of the insurance policy, and not prevent, or delay the insured from obtaining the benefits of the policies they purchased. When liability is reasonably clear, the claims process should seek to pay claims, rather than force litigation.

“Therefore, the claim representative's chief task is to seek and find coverage, not to seek and find coverage controversies or to deny or dispute claims. “ The Claims Environment, page 13

Insurers must debate fairly, so it is presumed there will be a diligent and even handed effort to find facts that support coverage, before contesting or denying coverage. Insurers who contest or deny claims must have a reasonable basis for doing so.

“Claims are seldom investigated too much.” The Claims Environment, page 44

The adjusters' job is to facilitate the use of the policy by properly resolving claims, i.e. promptly and fairly.

Underinsured Motorist Coverage and the Insurance Policy. The role of the insurance company is defined by the insurance policy as well as by state law. I am not citing case law, but every claims professional is charged with having an adjuster's understanding, or operational understanding of relevant insurance law to the extent it may involve the handling of a claim. This instant case involves uninsured motorist (UM) coverage. This is first party coverage, designed and intended to pay the insured

the verdict value (compensatory damages an insured person is legally entitled to recover...) in the case against the tortfeasor (at fault driver), who was uninsured. UM coverage exists so that the injury claim can be paid without the necessity of a trial. UM insurance is insurance against the absence of insurance. The UM grant of coverage defines what the insurer has promised, [5] which is for compensation of those damages the insured is legally entitled to receive.

In the UIM claim, the insured should be able to reasonably expect the insurer will make a good faith effort to attempt to establish what a jury would award in the case. To do so without guessing, the insurer must make a reasonable evaluation that is objective in nature based on the best available information, to determine a subjective amount. To be objective, and consistent with the insuring agreement, AMFAM should evaluate the damages with the knowledge of what the jury would be instructed to consider in arriving at a verdict on damages. The insured has the burden of proof in establishing his damages by a preponderance of evidence. From a claims professional perspective, it is understood that this requires the insured to show a preponderance of evidence, which is just enough evidence to persuade a fact finder that a fact is more likely to be true than not true.

The insurance company is responsible for fulfilling the promises outlined in the insuring agreements of the contract. While it is not my role to discuss state law with respect to the role of the insurance company, every insurer must adopt and implement systems for the prompt investigation and payment of claims. Insurers who fail to both adopt and implement reasonable policies and procedures for claims handling are at greater risk for improper claims practices. Adopting and implementing reasonable policies and procedures is discussed in more detail on the following page, concerning reasonable claims handling standards. The claims professional's duties arise after a reported loss.

Claims Handling Standards

Claims handling standards are foundational and fundamental to the delivery of the promises of the insurance contract. They are derived from the NAIC (National Association of Insurance Commissioners) Model Unfair Claims Settlement Practices Act [6], which nearly state has adopted in some form; administrative codes and statutes; case law; and even reasonable policies and procedures of some insurers. These standards are usually taught within insurance companies, as well as industry wide courses available to any claims employee, such as through the Insurance Institute of America. Indeed, most insurers encourage employees to obtain outside training within the industry, where such claims standards are taught and reinforced. Claims handlers typically know and understand these principles, and that they supplement and compliment states' Unfair Claims Practices act or regulations. Moreover, virtually all insurers incorporate the Model Act and the states' unfair claims handling acts as part of their claims handling procedures and guidelines, as does AMFAM, evidenced in its claims training materials I have reviewed. Such widely accepted standards make it possible for adjusters to assist in claims handling in other states when there is a need for additional staff. Indeed, these standards are typically included as measures that internal auditors or quality assurance reviews use to judge claims handling behavior.

Here, WAC 284-30-330, Unfair claim settlement practices are specific and defined reasonable industry standards that every responsible insurer and every reasonably trained claims professional in Washington would be guided by, be accountable to and be in compliance with. Insurers know that there are consequences for failing to follow these rules. And these standards represent minimal standards. AMFAM has adopted this. *Adopting* and *implementing* the reasonable insurance industry standards of claims work is critical to fair claims practices being evidenced. For example, an insurer:

• Must treat its insured's interests with equal regard as it does its own interests. This is not an adversarial or competitive process. Insurers should not use their superior financial advantage to the detriment of an insured. A reasonable insurer will give equal consideration or regard to the financial harm of an insured as it does to its own financial risk when making claims decisions. [7] The insured expects and deserves honest, fair treatment throughout the claim process.

• Should assist the insured with the claim. The insurer, through its claims department is expected to be experienced and knowledgeable in the business of claims. When insureds face unexpected loss, they are typically vulnerable-financially,

physically, and emotionally. They are not at their best, and should be able to rely on and trust the insurer to assist in the claims process. It would be wrong for an insurer to take advantage of an insured, especially when they are in particular need of help and assistance. [8] In the absence of assisting and enabling the insured to use the policy to obtain benefits, the insured faces unreasonable barriers in the claims process.

• Must acknowledge and act reasonably promptly to communications with respect to claims of its insured. Prompt and adequate communication is a foundational component of claims handling. Effective communication enables the claims process to move forward in a positive direction. If communication is not reasonably prompt and adequate it can cause unreasonable delay. Unreasonable delay has the effect of diluting the claims benefits. [9]

• Must adopt and implement reasonable standards for the prompt investigation of claims. [10] When insurers do no adopt and implement reasonable standards, claims handling may not be consistent. Without standards, claims handling decisions can be wrongful and harmful to an insured. [11] Learning by way of on-the-job training without standards in place means that the insurer learns by its wrongdoing, and this is usually to the detriment of an insured. When an insurer conducts its claims business without standards that are in place and followed, its consequential behavior is not considered a simple mistake or accident. Rather, the consequential behavior is predictable.

• Must fully, promptly, and fairly investigate and evaluate the claim, and must not refuse to pay a claim without conducting a reasonable investigation. [12] A reasonable investigation will vary depending on the claim. An insurer will cause harm to an insured if it denies a claim, or withholds benefits without a basis that is reasonable. A fair investigation is one that is honest and even handed, and that considers facts that support the claim equally to facts that do not. Because delay dilutes the benefits of insurance, investigations must be reasonably prompt, generally within thirty days. If an investigation remains open, an insurer should effectively communicate with its insured, specifically as to why the investigation remains open, what is needed to be completed, and timeframe for doing so. The insurer cannot put the burden of investigation on its insured.

• Must attempt to pay those claims when liability is reasonably clear and amounts are known to be owed. [13] For insurance to function as it is intended, claims benefits need to be both prompt and fair-not one or the other. Withholding benefits that are known to be owed dilutes the benefits by way of delay. The delay can also weaken the resistance of an insured, who is already vulnerable, and may force the insured to take less than is owed.

• Must pay all amounts not in dispute promptly, usually within thirty days. [14] Amounts of benefits owed to an insured should be paid as reasonably promptly as possible. Withholding and delaying benefits to an insured can only cause harm to an insured. When an insurer calculates benefits that are owed, prompt payment is warranted.

• Must disclose to the insured all benefits, coverages, coverage issues, and time limits that might apply to the claim. [15] Insureds need help from the insurer during the claims process. They should be able to rely on the insurer promptly disclosing all benefits and coverages that may apply to a loss. [16] Any coverage issue or even potential coverage issue should be disclosed to the insured as soon as it is known to the insurer. Insurers know they may be estopped or waive coverage defenses if such are not promptly communicated. Indeed, insurers will typically issue a reservation of rights to an insured upon first knowledge of a coverage issue.

• May not deny a claim, or any part of a claim, based on insufficient information, speculation, or biased information. [17] Claims decisions are to be made based on facts. [18] Claims decisions are too important to be without reasonable foundation. Unfounded or speculative decisions in the claims process and especially in a claim denial or compromise offer will undoubtedly cause harm to an insured. A claims professional understands claims decisions involving suspicion and conjecture are unfair and reckless. Such decisions also show a lack of regard to the interests of the insured.

• May not misrepresent facts or policy provisions. [19] Insurance policies are known as contracts of adhesion. Insureds do not bargain for the insuring agreement, conditions, definitions, or exclusions. The contracts are interpreted as written, with any ambiguities decided in favor of the insured. Insurers cannot impose conditions or provisions into the contract if they do not exist. If that were the case, insurers could post write policies such that the benefits are not collectible, simply by changing conditions, insuring agreements, definitions, or exclusions. Insureds should be able to expect honesty in all matters of the claim process.

• Must provide a reasonable explanation for a denial or compromise offer of benefits. [20] Without such an important and adequate communication, an insured will be at a loss to understand how an insurer determined the amount of benefits, what else may be needed to support the loss, or if the insurer made an honest mistake in arriving at the amount of benefit-or indeed in a denial. Claims decisions are too important to be whimsical or unsupported. Insureds should be able to have a reasonable basis to understand a compromise offer or denial, so they can have equal footing if the need to challenge arises. Insureds expect transparency and honesty in the claims process.

• Must document its file sufficiently to record all pertinent activities and events so a reasonable understanding of file activity can be recreated. [21] In the business of insurance claims handling, it is said that “if it is not in the file, it didn't happen”. Recording pertinent activities as they happen serves to allow understanding and transparency to anyone who has a need to look at the file handling-such as claims supervision or another adjuster assigned with file handling. It also allows an insured, internal auditors, or regulators to review the claims handling activities when such handling is brought under question.

• May not make unreasonably low offers of benefits. [22] Insureds are expected to be treated honestly, fairly and evenhandedly. Insurers know they cannot overreach their insured. This includes offers of benefits that are known to be low, or should reasonably be known to be low and unrepresentative. Doing so can wrongly force litigation to get benefits that are known to be owed. Litigation is financially and emotionally costly, and the process causes delay in benefit payment. These factors dilute the value of the benefit.

These claims handling standards are included in what is recognized as reasonable industry custom and practice. These standards are commonly referred to as the ‘rules of the road’ for claims handlers. They apply to insurers and claims handlers in the state of Washington. In fact, AMFAM is one of many insurers who has adopted the NAIC Model Act as well as individual states' unfair claims practices acts as part of what would be its claims handling standards, or best practices. These standards or rules are included in what any claims practices expert would rely on in evaluating an insurer's claims handling relating to reasonable industry custom or standard. [23]

In the fifteen years I have been involved in claims practices litigation, I cannot recall a situation when a claims professional or indeed an insurance 30 (b) (6) deponent who do not readily agree with these rules or claims handling standards, including AMFAM. While these rules or standards apply to insurers and claims handlers in Washington, they are recognized generally as accepted standards on a national basis. Indeed, AMFAM recognizes them by way of testimony and its claims training documents.

Analyzing insurance claims practices in relationship to accepted reasonable industry standards has proven to be a methodology that has been reliable, relevant, and accepted by both state and federal courts I have testified in, including Washington. These same standards are used to evaluate claims handling when insurers undertake closed file reviews to evaluate the work of its staff.

Brief Summary of The Patricia Potter Claim

LIABILITY: On June 1, 2014, Ms. Potter was hit broadside in an intersection in Pierce County, Washington. The driver who caused the collision was cited for causing the accident. He was cited for driving under the influence. Driving a vehicle without permission, he was denied liability coverage: he was an uninsured driver. AMFAM has not contested liability; Potter was fault free.

INJURIES: Ms. Potter was injured in the collision. She was diagnosed with a concussion, and head injury, as well as soft tissue injuries. She experienced problems with memory, balance, anxiety, and headaches. The events from the accident caused problems with stress, effecting her blood pressure.

SOURCES OF INSURANCE RECOVERY: The at-fault driver was not insured. Potter turned to AMFAM, making claim under the UM coverage, with available limits of $100,000 per person. The insurance policy did not contain any Personal Injury Protection, or Med Pay to assist with accident related medical expenses. The UM benefits of $100,000 was the single source for recovery.

REQUEST FOR BENEFITS: On July 31, 2015, Potter's counsel sent a policy limits request to AMFAM for the available $100,000 in UM coverage. All of the accident related medical bills and records were included. The medical bills exceeded $20,000, of which AMFAM accepted $19,973 as related. The documented wage loss accepted by AMFAM was $1,728.

AMFAM's EVALUATION AND RESPONSE: AMFAM evaluated and calculated the amount owed on the UM claim was $46,701 as the total claim value. This represented $19,973 in medical loss; $1728 in wage loss; and $25,000 for all general damages.

On August 31, 2015, AMFAM offered a compromise amount to Potter, in the amount of $41,701.

While AMFAM revealed the amount of general damages, wage loss, and medical expenses, AMFAM did not explain the basis for its calculation of its compromise offer. Potter requested arbitration under the terms of the policy on August 31,2015.

On January 6, 2016, AMFAM offered to settle the claim for $50,000. Potter again requested an explanation for the basis of its calculation. AMFAM refused. Thereafter, AMFAM took the plaintiffs treating providers' depositions, and scheduled a defense medical exam.

Arbitration took place February 29, 2016. The arbitrator awarded $130,259 to Potter.

This case was subsequently filed against AMFAM.

Conclusions

For the reasons set forth below, in summary of the claims handling, AMFAM failed to meet reasonable industry standards. This includes not conducting a prompt investigation; ignoring the preponderance of evidence that supported the claim; refusing to pay a claim based on guess or speculation; refusing to pay a claim when the liability is reasonably clear; misrepresenting the insurance contract; compelling litigation by refusing to pay UIM benefits or explain the reasons why it was withholding them; placing its financial interests ahead of the insured's financial harm. Further support for the basis of these conclusions follows:

AMFAM had questions about the relatedness and extent of the documented closed head injury. Though the medical records supported the injury and the continued symptoms, AMFAM did not evaluate the claim as having the cognitive problems alleged. Despite a recommendation from its Nurse Services to obtain a neurological medical exam, the adjuster failed to do so. In letters dated July 6, 2015 and August 5, 2015 to Potter's counsel, AMFAM promised it would have the claim reviewed by an independent consultant. No investigation was undertaken to rebut the preponderance of medical evidence. AMFAM failed to undertake any independent or defense medical investigation until months after it completed its evaluation and calculation of UM benefits, and after it denied paying the insured any of the benefits she sought unless she surrendered to a settlement. This is below reasonable industry standards.

AMFAM had no evidence to rebut the medical evidence documented in the providers' records as to the cause, nature, and extent of Potter's injuries. The preponderance of evidence-actually all of the medical evidence- supported the injuries and symptoms as causally related to the injuries sustained in the subject motor vehicle accident. Ms. Potter's claim was wrongly evaluated

because of speculation and conjecture. This is below reasonable industry standards. Indeed, the adjuster testified she had no medical training on concussions or traumatic brain injuries, again evidence her evaluation was guesswork.

Here, liability was not only clear, it was aggravated because of the tortfeasor being under the influence. AMFAM failed and refused to make payment of the benefits it determined were owed unless and until the insured resolved her claim-sign a release. This is below reasonable industry standards. When liability is reasonably clear, the policy should work to promptly pay.

In addition to misleading or being untruthful about having the file reviewed by an independent consultant, AMFAM misrepresented the policy in two ways. First, the claim was not evaluated to consider all of the compensatory damages the insured would be entitled to, which is what the insuring agreement promised. Rather than a coherent evaluation that considers all of the categories of compensable damages, the adjuster assigned a general damage number to the concussion, the soft tissue injuries, and for anxiety. There is no explanation how these numbers were sourced or based in the file. The adjuster testified she did not understand what a preponderance of evidence was. She testified she never consulted jury awards, or jury instructions. She testified her evaluation was completely different than how a jury would determine value. The second misrepresentation was demanding the insured sign a release to obtain benefits, and thus surrender the balance of any additional benefits she was owed. Misrepresentation is below the reasonable industry standard.

AMFAM unreasonably compelled litigation. This claim was not a fairly debatable claim, or put another way, there was no genuine disagreement as to the amount of damages. Before there can be a genuine disagreement, the insurer has to have completed a reasonable investigation based on all available facts, and have applied the insuring agreement and proper law to the calculation of damages. As described, AMFAM failed to do so. Moreover, the claim file documents that $46,701 is the “Total claim value”. Yet the adjuster offered $41,701, secretly trying to save 20% of what she calculated in general damages. While AMFAM stated its offer included $20,000 general damage, it failed to explain the basis of where the number came from, how it was calculated, what it was based upon. Upon receiving an offer for $50,000, Potter's counsel wrote to AMFAM on January 8, 2016, expressing frustration for what he explained to be a continuing failure of AMFAM to reasonably investigate and evaluate this claim. He offered AMFAM specific references to similar case outcomes that were substantially higher that AMFAM's evaluation. AFFAM undertook no investigation into this support. Potter's counsel posed two dozen questions to AMFAM, asking them to reasonably explain its investigation, evaluation, and compromise offer. AMFAM failed and refused to respond. Its evaluation remained a frozen assessment. The reasonable industry standard is to respond to pertinent communications, provide reasonable explanations for compromise offers. AMFAM failed to meet this standard. Compelling an insured to litigate without a reasonable basis is below the reasonable industry standard.

The reasonable industry standard is to promptly pay those claims when liability is reasonably clear. The reasonable industry standard is to affirmatively pay claims as promptly as is reasonable when liability is reasonably clear, and damages are known to be owed.

AMFAM has and continues to misrepresent policy conditions in the cases I review. It will not pay UM benefits unless and until the insured signs a release of claim. This is the standard business practice of AMFAM. This is contrary to the reasonable industry standard to not misrepresent or conceal policy provisions. The reasonable industry standard or custom is to attempt to address the needs of the insured, by allowing the policy to work as intended by softening the consequences of an unexpected loss. There is no policy condition here (or in any other UM/UIM policy I have seen) that conditions payment of benefits in exchange for a release of claim. It is a well-recognized reasonable standard that insurers are to not impose conditions not found in the policy, or to misrepresent conditions to an insured. Most state's unfair claims practices include this standard, including Washington. Indeed, American Family's training materials adopt and incorporate states' unfair claims practices in their training on good faith claims handling.

American Family has endorsed *The Claims Environment,* First Edition 1993, by James Markham, Kevin Quinley, and lane Thompson as a reasonable treatise on claims practices. On page 19, it states:

"Claims representatives handling first-party losses should promptly pay all amounts they know the insurer owes and should negotiate in a forthright, honest, and flexible manner over any amounts that are in dispute."

Robert J. Prahl, CPCU, Director of Education for the American Association of Insurance Services (AAIS), wrote an article titled "Bad Faith and Excess Liability-Insurer Conduct on Trial. On page 8/11, under the caption Settlement Negotiations, he states:

"Don't hold up the entire claim if part of it is not in dispute. Try to resolve the undisputed portion, and the concentrate on the disputed portion."

Within Safeco Insurance Company's "Ten Commandments of Bad Faith" are (1) Thou shalt not be a hero: Don't try to save part of the policy benefits; and (X) Thou shalt consider the insured's interests. Equal consideration; embraces all other duties.

In Edition #1, Basic Claims Training Program, Liability Training Text Uninsured/Underinsured Motorist Insurance of Farmers Insurance Exchange, the following is stated on page 18, under ARBITRATION:

"A. No Agreement

1.

a. If you have offered some amount to compensate the insured under the uninsured (or underinsured) motorist coverage, offer to have a partial check (or draft) in that amount issued (unless rejected by the insured) and arbitrate the disputed portion of the claim. NEVER withhold the undisputed portion as this would be to the detriment of the policyholder."

State Farm has the largest market share of automobile insureds in the country. It is and has been long standing that State Farm issues payment of offers of UM/UIM for the undisputed amount, or amount known to be owed.

I have been provided with Motions and Exhibits from the case of:

Mark Wells Paine and Denise Ann Paine vs. American Family Mutual Insurance Company, In The Iowa District Court in and for Cerro Gordo County, LACV 068221.

Exhibits 33, 34, and 35 to Motions in that case indicate that American Family recognizes it has a responsibility to make partial payments on a claim without a release or delay once the damages are reasonably supported. These exhibits illustrate American Family has had this position since 1990. For example, relevant language from Exhibit 33:

Quote From Exhibit 33:

"SUBJECT: PARTIAL PAYMENTS IN CLAIM SETTLEMENTS We are operating today in a legal climate which demand that claims be processed promptly, fairly, and in good faith. This is *as it should be. The insurance industry has brought many of its current problems upon itself because of past claims practices which today are reprehensible. Such practices may include:*

1. Refusal to pay for automobile damage or medical expense until a bodily injury claim is *settled.*

2. Refusal to settle with one family member until all family members settles.

3. Advising the claimant not to hire an attorney or pointing out the financial disadvantage in doing so.

4. Keeping the claimant in financial distress to encourage early settlement.

5. Harassing the claimant with demands for documentation of special damages that are beyond reason.

6. Delaying settlement to increase investment income

The above practices and any other designed to give the company unfair leverage in the negotiation of a claim settlement are prohibited.

In those cases where liability is *clear or probable, it is permissible to make a partial payment of a liability claim without a release for:*

1. Property damage.

2. Medical expense

3. Loss of net wages or other income.

4. Rehabilitation Services

5. Other specific economic loss .....

No release or written agreement is necessary, nor is one desirable, when making a partial payment."

(See Exhibit 33 *Claims memo from John S Patton, American Family Casualty Claims director, August 1990.)*

Exhibits 34 *and* 35 are internal claims memoranda confirming American Family's policy of making partial payments or advance payments as good faith claims handling in 1997, and 1998 respectively.

The following is American Family Claim Bulletin #029:

#029 - Partial Payments Claim Settlements

CASUALTY

November, 2006

The American Family Claim Division works diligently to handle every claim promptly, fairly, and in good faith. This is not only a Company standard, but also a legal requirement.

American Family Insurance Group is interested in the welfare of its insureds and claimants. We want to do everything within reason to see that the claimants' immediate economic concerns are addressed.

The reasons for making partial payments are to reflect the concern for the welfare of the claimants/insureds and to establish a good working relationship.

For these reasons, payments should be made as soon as it's practical and only with necessary documentation. Partial payments should be approached with a spirit of trust with the understanding that continuing payments will be discontinued if that trust is breached.

CASUALTY

In those cases where liability is clear or probable, it is permissible to make a partial payment of a liability claim without a release for:

1. Property damage

2. Medical expense

3. Loss of net wages or other income

4. Rehabilitation services

5. Other specific economic loss

There are some cases when partial payments need to be considered more carefully. For example, in Wisconsin, it has been held that a partial payment of a liability claim will extend the statute of limitations from the date of the last payment for the full period of the statute. We have a duty to protect the interests of the insured, which may be adversely affected if we cause the statute of limitations to run again after a partial payment. In the case of a Wisconsin claim potentially in excess of policy limits, the approval of a Company claim attorney is required before a partial payment is made. Medical expense coverage is a separate coverage intended for the early payment of medical bills without regard to liability. All medical expense claims must be paid upon submission if the charge appears to be fair with service necessary and related to the accident.

A release or written agreement is neither necessary nor desirable when making a partial payment. However, we will require the execution of a medical information authorization/employment authorization. Use this authorization promptly to secure medical and wage loss information to support the payment. The “In Payment of” line of the claim draft should clearly indicate it is a partial payment for the appropriate purpose.

Partial payments are not mandatory, but are a matter of customer service to alleviate the immediate needs of the claimant in appropriate cases. Remember, if it appears the claim is ready, or close to settlement, make every effort to settle the *claim* and secure a final, signed release. A C-387 “Record & Receipt of Advance Payment” Form (stock #00533) must be completed for each advance payment.

The preceding is evidence that AMFAM understands the importance of making partial payments since at least 1990 up to the present. This is additional evidence that even within American Family, that making partial payments is indeed recognized as a reasonable industry practice. In this regard, the insurer makes the decision to help or harm. Yet in 30(b)(6) testimony in *Carpenter, AMFAM* testified it never makes advance payments in UM/UIM cases.

The following is page 1 of American Family Claim Bulletin #638. This is instructive about the purpose of releases in UM/UIM claims.

#638 - Releases, Statements of Claim, Proofs of Loss &

Drafts

GENERAL

February 2011

RELEASES

A Release is a contractual agreement to give up or abandon a claim or right. Its purpose is to serve as written evidence of the settlement of the claim. A settlement draft serves as evidence of payment.

It is not necessary to take a Release in the following situations:

A. Property Damage

1. When dealing with anther insurance company. When another insurance company presents the deductible claim of its insured in addition to its own subrogated interest, issue a separate draft payable to the claimant for the amount of his/her deductible.

2. Property damage claims under $10,000 where there is no dispute as to the amount of the settlement.

B. Bodily Injury

1. Bodily injury claims under $1,000 where the settlement negotiations have been amicable.

***Uninsured/Underinsured* Motorist Claims**

The Proof of Claim (C-407) generally is unnecessary. However, this form should be requested early in the claim if the insured is uncooperative or evidence suggests potential for fraud.

In order to protect subrogation possibillities, a Release and Trust Agreement (C-327) or Release and Indemnity Bond Trust Agreement (C-406) form should be completed by the claimant seeking the UM coverage at the time of settlement in all cases. For Kansas, use forms 404 and 405.

In Underinsured Motorist claims, the Release and Trust Agreement (C-327) or Release and Indemnity Bond Trust Agreement (C-406) should be used. There may be unusual situations that occur under this coverage, such as when the Company advance pays an amount equal to the underlying liability limits of the tort feasor(s). In those instances, the Legal Department should be consulted in order to draft a suitable document.

The Bulletin states that a release is a contractual agreement to give up or abandon a claim or right. That is a direct address to my point that the UM/UIM contract does not give the company the right to call upon the insured to give up or abandon the claim or right. But that is exactly what American Family is insisting on in maintaining its position that it will not pay benefits unless and until the insured abandons the claim. It does state the purpose of the release is to subrogation possibilities.

There is no industry standard I am aware of that states it is reasonable for an insurer to withhold or refuse to pay amounts it has determined to be owed. Moreover, the reasonable industry standard is that an insurer must promptly pay amounts it determines are owed. I have not seen evidence American Family had a reasonable basis to withhold payment of UM benefits.

The reasonable industry standards call for the insurer to not compel litigation because it fails to conduct a prompt and reasonable investigation, fails to communicate its evaluation or reasons why it has denied payment on a claim when liability is reasonably clear, and fails to communicate with its insured any reasonable basis for not paying a claim. AMFAM did not meet these standards.

In sum, AMFAM has not treated its insured's interests with equal consideration. It has placed greater concern for its financial interests over the financial harm to its insured. This does not meet the reasonable industry standard of showing equal consideration, or for treating an insured honestly or fairly.

Based on AMFAM's own internal documents described above, it has knowledge that the claim practices I am critical of are “reprehensible” and evidence “unfair leverage”.

I have reviewed documents that address American Family's compensation programs, specifically its Corporate Incentive Program (CIP), and its Pay for Performance compensation system. American Family has proclaimed in its documents that it supports a “performance driven culture”. These compensation documents show the link of financial pay and bonus to achieving performance expectations that are linked to corporate goals. These goals include reducing claim severity. It is understood that arbitrary goals to reduce claims payments has no legitimate place in the claims office or with claims handlers. It is a recognized as a conflict of interest, because claims staff cannot control how many or how severe the claims will be, and goals that reward lowering claims payments without a legitimate basis are a recipe for trouble. It is contrary to reasonable industry standards to have compensation programs that set arbitrary goals of claim payment reduction and that then measure and reward (or punish) the employee for related performance is reaching such goal.

I have accepted over two dozen assignments to review AMFAM claims practices. In most or all of these, I opined that the claims handling practices failed to meet reasonable industry standards, sometimes involving a gross deviation. These cases mostly involved significant injuries and high UM/UIM limits. I have also declined, or reviewed several AMFAM cases where I felt the claims handling issues were not gross deviations from reasonable industry standards. The issues were not such that it involved issues of indifference, recklessness, but rather debatable issues that were reasonably debated. These cases tended to be smaller in scale of injury and UM/UIM exposure. I have reviewed these cases from across the country, including WA, ID, MT, SD, CO, AZ, IN, NV, and IA.

From my work on these cases, I have become familiar with AMFAM corporate documents that have been ordered to be produced. Many of these documents have been introduced as exhibits in open court, and have found their way into the public domain. The documents I reference include those associated with the Corporate Incentive Plan (CIP) and those associated with the Pay For Performance compensation system. Even now, AMFAM's web site describes how it rewards individuals who contribute toward established business goals, and this is accomplished through its CIP and Pay For Performance compensation programs. These documents boast that AMFAM has established a “Performance Driven Culture”. What has been problematic is that the business goals focus on reducing claims payments, and actually setting specific target goals for reducing claim severity, or average paid claims.

Regarding the CIP, AMFAM measures the results of combined ratio goals. The combined ratio is an underwriting snapshot of profit, comparing the expense ratio and the loss ratio to earned premium. A combined ratio above 1.0 means the company is paying out more in expenses and claims payments than it is realizing in earned premium. For instance, a combined ratio of 1.05 means the company is paying out in expenses and loss payments 5 cents more for every dollar of earned premium. While not desirable long term, a combined ratio over one is not at all uncommon for periods of time.

Insurance companies have surplus that earns interest or return on investment that allows them to deal with such cyclical underwriting cycles. American Family has surplus approaching $6 billion.

Claims employees do not sell insurance, so they have no effect on generating premium. Insurance is a mature industry. Companies have long ago found out how to cut expenses, yet they still have salaries, equipment, building, etc. that don't offer much meat on that bone. Claims payments are the largest portion of the premium dollar, and it is claims payments that adjusters can influence, and in term contribute to a lower combined ratio.

The Pay For Performance compensation program rewards those whose performance results support the corporate goals. With the focus on reducing severity at the claims handling level, claims staff can face a conflict of interest-financial interest. Simply stated, the less paid out in claims, the higher financial reward to the employee. At a minimum, this pay scheme invites mischief. Adjusters can lose sight that the insured is the customer, deserving of every benefit owed under the policy. If behavior descends,

claims handling becomes adversarial to the point that insureds are treated like third parties, and efforts focus on defeating claims. These pay schemes that reward claims staff for lowering payments have been at the heart of the last three AMFAM trials I have testified in. They are at issue here.

Sales/marketing, underwriting, and actuarial departments are legitimately concerned with making a profit. Using the laws of large numbers, losses become predictable, and proper rates are charged for the risks that are undertaken. There is profit built in when done properly. However, trouble brews when goals are set, measured, and rewarded outside the departments responsible for predicting losses. An individual office, let alone smaller departments or even adjusters have no way to control how many losses they will handle, or how large the losses will be, or what kind of policy limits are available to compensate those losses. A truism in this industry, which I have seen expressed in writing within several insurers, is that what gets measured gets done. This can invite claims handling practices that unreasonably delay or even deny payable claims. An example of this is the negotiation training materials I have reviewed. AMFAM places great emphasis on training its staff to be expert in the art of negotiation. It emphasizes the power that comes to those with expertise in negotiation- such as the power of the checkbook, the power of waiting, litigation power, the power of home-field advantage (court). These are tactics designed to control the claim process and to win. Maybe for adversarial third party claims, but perverse tactics against the insured. Insureds need and deserve assistance, not resistance. Resistance is known to weaken resolve, and delay is a form of resistance. Recent Rule 30(b)(6) testimony from the *Carpenter v AMFAM*[24] case stated that AMFAM treats first party claims the same as it does third party claims, and the jury voted against such tactics. So did the juries did in *Tonn* and *Sobieski.*

AMFAM uses industry data, provided by Insurance Services Office (aka ISO) to measure itself against its competition. Specifically, AMFAM uses severity data, known as Fast Track data as a means to set goals for severity. If AMFAM's severity is higher than the competition, the goal is to bring it down, below. If AMFAM's severity rating is below the competition, the goal is to maintain it. It is of no matter if AMFAM is 25% higher or lower. The basis is how it compares relative to the competition. The comparisons are done by state, region, and entire country. This is a problematic undertaking, and misplaced as a performance based, incentive rewarded scheme. First, if using the competition is a legitimate basis for comparison, then it would seem AMFAM should be as concerned for paying significantly less as it is for paying significantly more as far as average paid or severity. Second, many variables are involved in a resulting severity, such as number of and seriousness of injuries. Also at play is what available coverage limits are among and between insurers. Available policy limits has a play in determining severity. Chance also plays a role, as does the type and degree of risk that individual insurers are willing to undertake and the associated rates that are charged. The Fast Track data is not profit defining data. It simply compares average paid claim.

While claims staff must be diligent and responsible for claims decisions and payments, ensuring claims are not overpaid, it cannot have a legitimate goal to lower claims severity to specific numbers. Further, from my work on analyzing AMFAM claim practice cases, I have seen no evidence to support that lowering claims severity is related to AMFAM overpaying claims. I have reviewed quality assurance reports and reviews, office and state performance results and plans. These documents show that AMFAM is not overpaying claims (no analysis of underpaying claims was undertaken), and supports my opinion that there is no legitimate basis for creating these goals and incentivizing claims staff with financial reward for reaching them. The function of claims is service, to make good on the promise to pay, and to do so without temptation to self-serve. AMFAM's self-described Performance Driven Culture has normalized what otherwise is recognized as abnormal behavior because of these very specific, communicated, and measured goals of profit and severity. In my opinion this culture has a direct nexus to the wrongful claims practices I have seen in this and other cases. And while I have many AMFAM documents that were trial exhibits, and now in the public domain, I have never been contacted by anyone within the insurance industry and asked to see or obtain a copy. I have had similar corporate documents from most major insurers that are not subject to protection, and not once in the past 15 years have I ever been contacted by anyone within the insurance industry seeking these documents. Insurance is a mature industry. The institutional or corporate documents I have reviewed and collected from dozens of insurers differ little from one company to another, and in my opinion are not unique. After all, there are a limited number of ways to conduct the business of claims work: investigate, evaluate, communicate, and negotiate. These lead to the decision to pay, deny, or defend. Insurance is specialized, but it also is a copy-cat league, like the NFL. As soon as one company tries something, the rest follow-so long as they can do so, it is profitable to do so, and they are not caught in wrongdoing. These documents do not rise to the level of

Colonel Sanders' Secret Recipe, or the secret formula of Pepsi. The only interested parties to these corporate type documents are litigants who have brought under question claims practices of insurers, and wish to avoid the cost, delay, and possibility that a court will not compel their disclosure. There is value to insureds who become litigants who seek these 'secret' documents of their insurers. The concern for the insurer is that the public will see them, not a competitor.

The criticisms I have described are not the result of an adjuster gone rogue. This adjuster was not properly trained and equipped to discharge her duties to properly investigate, evaluate, communicate, and pay. This claim was supervised, so the claims practices I am critical of are condoned, encouraged by management. The adjuster testified she did not do anything improper. Indeed, her representative work has since earned her a promotion to casualty claim manager, where she can extend her style of claim practices and version of industry claim standards to those she will hire, train, supervise, evaluate, and reward. Metaphorically, this resembles an abandoned drift net at sea, causing repeated harm until removed. The criticisms I have described are the result of standard business practices at AMFAM, which are encouraged, measured, and rewarded. These practices are recognized as harmful and wrongful in the professional landscape of insurance claims practices. AMFAM knows this by way of its training documents and bulletins, some of which I have included in this report. It knows as a result of corporate testimony I have read and identified. It knows as a result of previous court verdicts. The harm of such conduct for unreasonable investigation, evaluation, communication, delay and denial of policy benefits, and compelled litigation is known and expected. Nothing in the claims handling here was by way of mistake or accident.

I will review any additional discovery, and reserve the right to supplement my opinions.

Footnotes

1 I am a claims professional; I am not a lawyer. If any advocacy is found in this report, it is to support fair claims practices only. This report will not contain legal opinions. If legal precepts are discussed, they will be general commentary about the claim industry's published understanding thereof.

2 "Claims professionals should have expert knowledge of insurance policy coverages, the law, and the determination of damages". Page 6. The Claims Environment (1 st Edition 1993). Insurance Institute of America. James Markham, Kevin Quinley, Layne Thompson

3 The deposition date was December 5, 2013. The case was Katlyn Tonn & Megan Fox v. AMFAM. Iowa District Court for Cerro Gordo County. Case LA cv 66679

4 My efforts are undertaken to help explain and educate insurance issues that are known to be confusing and complex to many. Education and explanation will assist the fact finder by providing a greater understanding, and hopefully add efficiency to a challenging task. Lest it be pointed out by the Defendants as a negative issue, I have in fact given a similar discussion of the general principles of insurance, the role of the insurance company, and claims handling standards in other cases. This does not demonstrate a cookie-cutter approach by myself. Rather, it demonstrates that these topics and duties are in fact common and consistent nationally, as among all policies and carriers. Regarding AMFAM, it perhaps speaks to pattern and practice, as I am reviewing similar behavior that courts have found unacceptable.

5 It must be noted that AMFAM never raised or reserved its rights regarding a coverage issue of any kind. Liability was 100% adverse to the at fault driver. The sole matter at issue in the UM contract claim was how much in benefits were owed to Ms. Potter.

6 "This act establishes guidelines on what constitutes improper claim handling." *The Claims Environment,* page 24.

7 "It is to the insured that the insurance company owes the contractual obligation of utmost good faith and fair dealing." *The Claims Environment,* page 18. "...the insurance company should not place its interests above the insured's". *The Claims Environment,* page 13.

8 "The claim department, and specifically the claim representative, is responsible for assisting people in presenting their claims to the insurance company." *The Claims Environment,* page 374. "The insured or claimant needs the claim representative's expertise and guidance." *The Claims Environment,* page 375.

9 See WAC 284-30-330(2). "Communication is essential to good claim work." *The Claims Environment,* page 109. "Insureds and claimants have questions that deserve prompt and accurate answers." *The Claims* Environment, page 303

10 See WAC 284-30-330(3).

11 "Allowing oneself to handle a matter without the required competency is a fundamental breach of duty to the customer." *The Claims Environment,* page 397. "Claim representatives must be especially expert in determining damages." *The Claims Environment,* page 59

12 See WAC 284-30-330(4).

13 See WAC 284-30-330(6). "When a covered loss occurs, the insurance company's obligation under its promise to pay is triggered. The claim function should ensure the prompt, fair, and efficient delivery of this promise." *The Claims Environment,* page 6

14 "Claim representatives handling first party losses should promptly pay all amounts they know the insurer owes and should negotiate in a forthright, honest, and flexible manner over any amounts that are in dispute." *The Claims Environment,* page 19. See WAC 284-30-380, and WAC 284-30-330(16).

15 See WAC 284-30-350.

16 "Policy language is sometimes difficult to understand." *The Claims Environment,* page 278. "The insured or claimant needs the claim representative's expertise and guidance." *The Claims Environment,* page 375

17 "An investigation must often be undertaken to fully develop the facts needed to determine coverage. Good faith claims practices require that this investigation be objective, thorough, and timely." *The Claims* Environment, page 29. See WAC 284-30-330(4).

18 "Claims are seldom investigated too much." *The Claims Environment,* page 44

19 See WAC 284-30-330(1), and WAC 284-30-350.

20 See WAC 284-30-330(13).

21 "The standard for documentation is that the file should speak for itself." *The Claims Environment,* page 340. See WAC 284-30-340.

22 See WAC 284-30-330(6)(7).

23 I will not cite to case law, however as a claims professional, I am aware of case law that speaks to these reasonable claims handling standards as a claims professional should understand while engaged in the duties of claims handling.

24 US. District Court Judge Kane, in the Order For Entry Of Judgment, referred to the withholding of UIM benefits known to be owed in exchange for a release surrendering the balance of available benefits as extortion.

End of Document