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August 8, 2025

Commissioner Patty Kuderer
Office of Insurance Commissioner
5000 Capitol Blvd
SE Tumwater WA 98501

Re: Comments on R2025-05 - Clarifying and updating minimum standards for claims handling

Dear Commissioner Kuderer:

We are writing to provide our comments on the recently proposed changes to the Washington Administrative Code. We are writing solely in our capacity as a firm and not on behalf of any clients that we currently represent or may have represented in the past. As a matter of background, our firm frequently handles first and third party bad faith and coverage disputes on behalf of insurers in the State of Washington . We are familiar with many of the recent trends with claims handling as well as recent trends of public adjusters, restoration contractors and third-party vendors.

Overall, we have seen mitigation and construction costs increasing across the board. We have also seen in increase of activity from specific public adjusters, restoration contractors and policyholder law firms that frequently and repeatedly show up in the matters we handle.

Respectively, the changes proposed will likely only increase instances of complaints from insureds, decrease the likelihood of compliance, and encourage more litigation. Thank you for considering our comments as part of this process.

We look forward to a continued dialogue with your office.

I. COMMENTS

WAC 284-30-300 Authority and purpose. RCW 48.30.010 authorizes the commissioner to define methods of competition and acts and practices in the conduct of the business of insurance which are unfair or deceptive. The purpose of this regulation, WAC 284-30-300 through 284-30-400, is to define certain minimum standards which, if violated ~~with such frequency as to indicate a general business practice~~, will be deemed to constitute unfair claims settlement practices. This regulation may be cited and referred to as the unfair claims settlement practices regulation.

(1) If any provision of WAC 284-30-300 through 284-30-400, or the application of such provision of WAC 284-30-300 through 284-30-400 to any person or circumstances, shall be held invalid, the invalidity does not affect other provisions which can be given effect without the invalid provision or application, and to this end the provisions of these sections are severable.

This change makes any single technical violation an unfair claims practice, even if done negligently without intent. The severable clause is also unnecessary and appears to be included specifically with the intent to make it difficult to challenge this overhaul of provisions.

~~(1)~~(2) "Claim" means either a request for a payment of insurance benefits, or any communication which indicates that a loss or harm occurred for which payment may be owed, or both. An inquiry from an insured to their insurance company relating to either the claim process, or coverage available under the policy, or both, does not constitute a

The definition of "Claim" is often defined in the policy and this effectively attempts to rewrite policy language. Additionally, it is unclear whether it applies to third-party liability claims or first party claims. Does an insurer have to complete an investigation, meaning a determination of indemnity and liability within 30 days of the underlying lawsuit being filed? Often times, the value of the claim and liability is not determined until trial. Again, this definition appears unworkable in the third-party context.

~~(11)~~(12) "Investigation" means all activities of the insurer directly or indirectly related to the determination of liabilities, including but not limited to, the consideration and calculation of amounts owed, under coverages afforded by an insurance policy or insurance contract.

What is the purpose of this change? By including one example, but not others, it unnecessarily defines the term. Additionally, this places an untenable burden on insurers to complete all investigation of amounts owed within 30 days, even if the insured has not provided relevant information. For example, in the first party context, if the insured has not provided information related to a contents claim, under this provision, arguably the insurer must still determine how much is owed for said contents within 30 days. Given the follow-up restrictions regarding all

information that must be included in the 30-day notice letters, this also is completely unworkable and likely not able to be reasonably complied with. This will increase the amount of complaints with the commissioner's office rather than reduce them, which was the office's stated intent.

(15) "Notification of claim" means:

(a) A~~a~~ny notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to the insurer or its agent, either by a claimant, their representative, or both, which reasonably apprises the insurer of the facts pertinent to a claim~~.~~; and

(b) Any notification, in writing or other means, to the insurer, its agent or legally liable party, by a third party claimant which reasonably apprises the facts pertinent to a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of the insurer.

Under this definition notice to an insured would constitute notice to an insurer therefore triggering an insurer's timelines to respond notwithstanding it has no actual notice of a claim. This would also be completely contrary to the selective tender rule under *Mutual of Enumclaw v. USF Ins. Co.*, 164 Wn.2d 411 (2008).

without conducting a reasonable investigation. A reasonable investigation includes, but is not limited to, conducting an individual assessment of either the covered loss, or damages, or both, and cannot rely solely on the use of a database.

WAC 284-30-330 Specific unfair claims settlement practices de- fined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

(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

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prompt investigation of claims arising under insurance policies.

(4) Any denial or refusal~~Refusing~~ to pay claims in part or in full without conducting a reasonable investigation. A reasonable investigation includes, but is not limited to, conducting an individual assessment of either the covered loss, or damages, or both, and cannot rely solely on the use of a database.

Why give examples as to a "reasonable investigation"? Is it intended to be subjective or objective? There is also no definition of "database" and no guidance on what constitutes an "assessment". A singular example of a reasonable investigation without more, will cause more confusion and ambiguity in this context. This provides less clarity, not more. The statement of prohibitions against participants in an "investigation" that "rely solely" on a "database" without even attempting to state what is a permissible computer-housed collection of information (including collections of human-observed data), and what constitutes a prohibited "database", and/or without even attempting what constitutes "sole" reliance, is plainly arbitrary and capricious.

(5) Failing to affirm or deny coverage of claims within a reasonable time after receiving notification of claim.~~fully completed proof of loss documentation has been submitted.~~

Notification is not the only requirement under the policies, however, it appears these rules are intended to write any type of cooperation on the part of the insured out of the policy. This appears to unnecessarily shift any responsibility for articulating the basis of the insured's loss from the insured to the insurer, and may encourage individuals to not cooperate. The only

requirement for a violation of this provision is that the insured provide notice, without regard to whether the insured cooperated, provided a proof of loss or information related to the loss.

(11) Delaying the investigation or payment of the claim~~s~~ by requiring either a ~~first party~~ claimant, or his or her service or medical provider~~physician~~, or both to submit documents or information~~a preliminary claim report~~ and then requiring subsequent submissions which contain substantially the same information.

Does this impose a duty on insurer with respect to third-party claimants? This may be used to attempt to bring direct actions against the insurance company. It also diminishes any type of cooperation by plaintiffs in having to prove their injuries in a liability context. To the extent medical records are subsequently requested in a lawsuit, does that constitute a "delay in investigation" by requiring the claimant to resubmit medical records?

(14) Unfairly discriminating against claimants because they are represented by a public adjuster. This includes, but not limited to, failure to recognize the public adjuster as the legal representative of the insured, and timely provide requested pertinent claim information and insurance policy to either the represented insured, or public adjuster, or both.

This appears to unreasonably define "discrimination" as not providing a copy of an insurance policy, even if done negligently. This also appears to encourage public adjusters to unnecessarily request claims information and policies even if they have already been provided to insureds. The public adjuster is also deemed a "legal representative" even though they are not licensed to practice law.

(20) Failing to accept the first party claimant's emergency mitigation invoice when there is a duty in the policy for the first party claimant to protect the property from further damage after a loss event. "Emergency mitigation" in this section means the actions necessary to stabilize the loss so the insured has satisfied the duty in the policy. This may include, but is not limited to, boarding up, tarping a roof, removing standing water and beginning the drying out process. A non-emergency mitigation scope that covers the complete process of removing material or continuing the dry out can be developed by either the first party claimant, the insurer, or both.

(21) Failing to approve the first party claimant's scope of non-emergency mitigation within three business days after submission when there is a duty in the policy for the first party claimant to protect the property from further damage after a loss event. If the insurer rejects the first party claimant's scope of non-emergency mitigation, the insurer must disclose to the first party claimant all reasons the scope of mitigation does not meet either the technical, or industry

standards, or both, and the insurer must provide the first party claimant with the approved scope of mitigation that will prevent the property of further damage from the covered loss within the same three business days.

(22) Requiring an appraiser functioning under the appraisal clause in the policy to adjust either their actual cash value, or their valuation of loss, or both, at any time during the appraisal process. This does not prohibit the insurer from applying the policy conditions to a completed appraisal award.

~~(19)~~(23) Knowingly or negligently providing inaccurate information to a specialty consumer reporting company, thereby harming a consumer's insurability.

Emergency mitigation is not used uniformly across policies, and this re-writes policy language that has already been approved by the insurance commissioner. This will likely encourage collusion between the mitigation company and public adjusters. Additionally, invoices are not submitted for approval typically until after the work is completed. Therefore, the need for three business days turn around would appear moot at that point.

This will likely encourage restoration companies to charge non-emergency mitigation costs and label them as "stabilization." In the defense bar, we are experiencing increased instances of predatory practices by mitigation and restoration companies and many have implemented over-demolition, over-charging, and foreclosure actions as standard business practices. The vagueness of IICRC guidelines, for example, allows over-demo and over-charging on dry-out in crawlspaces, attics and other areas. The insured unfortunately is often caught in between and unknowingly being taken advantage of. This is becoming a "cottage-industry" based on the number of lawsuits pending over mitigation and restoration invoices in the state of Washington.

As to the non-emergency mitigation invoice, this provision effectively writes out of the policy the appraisal process, as it requires insurers to provide a competing scope within 3 business days or risk extra-contractual exposure. We believe this will increase the likelihood of Public Adjusters, who receive 10% of the recovery, to over-scope, over-demo and increase rates across the board.

This provision also effectively writes out of the policies the requirements that the repairs need to be reasonable and necessary. Rather it's effectively an expedited appraisal process in 3 business days.

WAC 284-30-340 File and record documentation. A violation of the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance:

(1) The insurer's claim files are subject to examination by the commissioner or by duly appointed designees. The files must contain all notes and work papers pertaining to the claim in enough detail that pertinent events and dates of the events can be reconstructed.

(2) First party claimants shall have the right to request and receive from the insurance company any portion of the claim file, including but not limited to all written reports, estimates, bids, plans, measurements, drawings, engineer reports, contractor reports, statements, photographs, video recordings, or any other documents or communications unless the record that the insurance company prepared or used during its adjustment of the policyholder's claim is either legally privileged, or specific investigative records where the nondisclosure of which is essential to effective investigation of alleged criminal activity, or both. The insurer has 15 business days to provide all of the appropriate requested claim documents to the first party claimant.

We believe this will unnecessarily hinder the insurer's ability to investigate fraud. If the insurer must disclose portions of the claims file, except only where investigation of "criminal activity" the provision essentially bars any type of good faith SIU activities based on suspected fraud. It also places an unnecessary burden on insurers that are greater than public record requests for government entities. This will likely result in lawsuits based solely on the failure to turn over materials within 15 business days. It also potentially allows "first party claimants" to obtain information of other insureds that should not be disclosed. The definition of "first party claimant" is often argued to be broader than simply an "insured".

WAC 284-30-360 Standards for the insurer to acknowledge pertinent communications. A violation of the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance:

(1) Within five~~ten~~ business~~working~~ days after receiving notification of a claim under an individual insurance policy, or within 10~~fifteen~~ business~~working~~ days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification of a claim given to an agent of the insurer is notification of a claim to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within 10~~fifteen~~ business~~working~~ days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within five~~ten~~ business~~working~~ days for individual insurance policies, or 10~~fifteen~~ business~~working~~ days with respect to communications arising under group insurance contracts.

(4) Upon receiving notification of a claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable

This places an undue burden on insurers that is not consistent with any other jurisdiction. There is no justifiable reason to change the time required to respond, other than to increase complaints and the filing of lawsuits.

WAC 284-30-370 Standards for prompt investigation of a claim. A violation of the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance:

(1) Every insurer must complete its investigation of a claim within 30~~thirty~~ calendar days after notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

(a) If the insurer needs more time to investigate the claim it must notify the claimant in writing of the reasons it cannot complete the investigation of the claim within 30 calendar days from the notification of the claim.

(b) If needed, additional written notice must be provided every thirty days after that date explaining why the investigation of the claim remains unresolved.

(i) For the purposes of this subsection, the additional notice must include a summary of any decisions or actions that are substantially related to the disposition of a claim, including, but not limited to:

(A) The amount of loss to structure or contents, or both;

(B) The retention or consultation of repair professionals;

(C) Every item the company is waiting on to complete its investigation of the claim; and

(D) If a new adjuster is assigned, confirm the new adjuster has reviewed the claim file and is prepared to timely continue the investigation.

These changes apparently are not limited to first party claims, and therefore create unnecessary busy work for insurers. This is also inconsistent with the Supreme Court's case law regarding what is required from an insurer when updating an insured. *See Staples v. Allstate*, 176 Wn.2d 404 (2013).

This is an onerous and unnecessary burden intended only to allow claimants to file more lawsuits in an attempt to hold insurers liable for technical violations of these provisions. This also appears to be wholly distinct and different than any jurisdiction that utilizes the uniform claims handling code.

WAC 284-30-380 Settlement standards applicable to all insurers.

A violation of the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance:

(1) Within 30 calendar days~~fifteen working days~~ after receipt by the insurer of notification of a claim, ~~fully completed and executed proofs of loss,~~ the insurer must notify the~~ first party~~ claimant whether the claim has been accepted or denied. The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion

(7) Insurers are responsible for the accuracy of their evaluations to determine the amounts owed under the applicable insurance policy for property damage~~actual cash value~~.

~~(7)~~(8) If an insurer uses a database or survey to account for either material pricing, or labor rate, or both, and upon request of the claimant, the insurer must provide the claimant with the date the data was collected, where the data was collected from, which businesses provided the data, and whether the business will honor the price provided if the insured were to consider using them.

This will increase the burden on insurers in preparing evaluations and estimates across the board. The intent appears to be to challenge the use of Xactimate in estimating repairs. By requiring an insurer to prepare estimates not using tools such as Xactimate, the claims handling costs will increase exponential and such increased costs will be born by the consumer and/or insurer will withdraw from the marketplace.

If an insurer has to hire a contractor to prepare a competing bid on each claim, and the insurer handles hundreds and thousands of claims, the cost-overruns will make it untenable for an insurer to do business in the State of Washington based on current premium charges.

Thank you again for consideration of these comments. We look forward to any additional opportunities to provide comments. The above views are solely those of the undersigned and not the views of any clients that Forsberg & Umlauf has represented in the past, now represents or may represent in the future.

Sincerely,

FORSBERG & UMLAUF, P.S.

s/ *Ryan Hesselgesser*

Ryan J. Hesselgesser