VIA EMAIL

August 8, 2025

Commissioner Patty Kuderer
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, Washington 98504
rulesc@oic.wa.gov

Re: Comments on R 2025-05 – Clarifying and updating the minimum standards for claims handling

Dear Commissioner Kuderer:

Thank you for the opportunity to submit comments on the draft amendments to R 2025-05 about minimum standards for claims handling in Washington under WAC chapter 284-30.

We circulated the draft amendments to our membership, comprised of over 700 defense lawyers across Washington. After seeking input from our members, we respectfully submit the following comments on behalf of the WDTL membership:

WAC 284-30-300 Authority and purpose

Comments on proposed modifications to subpart (1):

Our membership is concerned that this change makes any single, technical violation an unfair claims practice, even if done negligently without intent. Deleting the requirement that violations be frequent "as to indicate a general business practice" means even an inadvertent or excusable violation could subject an insurer to treble damages and other extreme penalties. And the severability clause is also unnecessary and is included specifically to make it difficult to challenge this overhaul of provisions.

Our membership is concerned that this modification imposes a duty on an insurer for third-party claimants. Doing so raises numerous concerns with our members because third-party plaintiffs will likely use this modification to bring direct actions against insurers. In addition, our membership is concerned that this modification diminishes any type of cooperation by plaintiffs in having to prove their injuries in a liability context. For a real-world example, in a case where medical records are later requested in a lawsuit, does that constitute a "delay in investigation" by requiring the claimant to resubmit medical records?

Comments on proposed modifications to subpart (2):

The definition of "claim" is often defined in certain insurance policies, and our membership is concerned that this proposed modification effectively attempts to

rewrite policy language. Our membership also notes that the subpart is ambiguous and unclear about whether it applies to third-party-liability claims or first-party claims.

For example, must an insurer—within 30 days of the underlying lawsuit's filing—complete an investigation and determine liability and how much is owed? Often, the issue of liability and the claim's value cannot be determined until the close of discovery or near the start of trial. This definition, as currently proposed, is unworkable in this context.

Comments on proposed modifications to subpart (3):

The definition of claimant, together with the added definition of claim, could be construed so that third-party claimants (*i.e.*, non-policyholders) may bring claims under IFCA. This provision needs more clarity.

Comment on proposed modifications to subpart (5):

Notification is not the only requirement of insureds under insurance policies. But it appears these rules are intended to write any type of cooperation on the insured's part out of the policy. This unnecessarily shifts any responsibility for articulating the basis of the insured's loss from the insured to the insurer and encourages individuals not to cooperate. The only requirement for a violation of this provision is that the insured provides notice, irrespective of whether the insured cooperated or not.

Comments on proposed modifications to subpart (12):

Our membership would like to understand the purpose of this change so they can better understand the effect it will have. By including one example, but not others, it unnecessarily defines the term.

As proposed, this places an untenable burden on insurers to complete all investigations of any amounts owed within 30 days, even if the insured has not provided relevant information necessary for such an investigation to occur. 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 the contents within 30 days. Given the follow-up restrictions about all information that must be included in the 30-day notice letters, this amendment also is completely unworkable and likely not able to be reasonably complied with. This will increase the number of complaints with the commissioner's office rather than reduce them, which was the office's stated intent.

Comments on proposed modifications to subpart (14):

Our membership is concerned that this modification unreasonably defines "discrimination" as not providing a copy of an insurance policy, even if done

negligently. Further, as drafted this encourages public adjusters to unnecessarily request claims information and policies even if they have already been provided this information to insureds. This also treats the public adjuster as a "legal representative" even though they are not licensed to practice law.

Comments on proposed modifications to subpart (15):

Under this definition, notice to an insured would constitute notice to an insurer and therefore would trigger an insurer's timelines to respond, even though it has no actual notice of a claim. This would also be completely contrary to the selective tender rule under *USF v. Mutual of Enumclaw*.

Our membership believes this modification provides less clarity, not more, because a singular example of a reasonable investigation without more causes more confusion and ambiguity. 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."

Comments on modifications to subpart (20):

Emergency mitigation is not used uniformly across policies, and this modification re-writes policy language that has already been approved by the insurance commissioner. This encourages fraud and collusion between the mitigation company and public adjusters. Additionally, there are concerns about the timing and logistics because, in practice, the invoices are not submitted for approval typically until after the work is completed. So the need for a three-business-day turnaround is moot at that point. This amendment will encourage restoration companies to charge non-emergency mitigation as stabilization. In the defense bar, we are seeing increased instances of predatory practices by mitigation and restoration companies, and many have implemented over demolition, over charging, and foreclosure as standard business practices to recover more money. The vagueness of IICRC guidelines, for example, allows over-demo and overcharging 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 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 three business days or risk extra-contractual exposure. This will increase the likelihood of public adjusters, who receive 10% of the recovery, to over-scope, over-demo, and increase rates in all estimates to insurers.

This provision also effectively writes out of the policies the requirements that the repairs need to be reasonable and necessary. Instead, it is effectively an expedited appraisal process in three business days.

WAC 284-30-330 Specific unfair claims settlement practices defined

Comments on proposed modifications to subpart (4):

The added language about not being able to rely "solely on the use of a database" is impermissibly vague. At a minimum, this amendment should be clarified.

WAC 284-30-340 File and record documentation

Comments on proposed modifications to subparts (1) and (2):

This unnecessarily hinders 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.

Producing a claim file before litigation, and within 15 business days, could present a real challenge and seems unreasonable. The insurer would have to retain counsel, and counsel would have to get up to speed and conduct a review of the entire file on quick turnaround. Claim files are often thousands of pages. It also places an unnecessary burden on insurers that are greater than public-record requests for government entities. This will 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 not limited only to "insureds."

WAC 384-30-360 Standard for the insurer to acknowledge pertinent communications.

Comments on proposed modifications:

This amendment places an undue burden on insurers. No justifiable reason exists 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.

Comments on proposed modifications:

These changes apparently are not limited to first-party claims and may create unnecessary work for insurers. And these changes may violate precedent from our state supreme court.

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 384-30-380 Settlement standards applicable to all insurers.

<u>Comments on proposed modifications</u>:

This amendment will increase the burden on insurers in preparing evaluations and estimates across the board. The intent is 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 exponentially. Those increased costs will be borne by the consumer. And insurers may altogether withdraw from the marketplace.

If an insurer must 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 Washington based on current premium charges.

Our membership appreciates the opportunity to comment on the proposed rule amendments. We look forward to continuing the dialogue on this issue important to our membership.

Sincerely,

/s Rory D. Cosgrove

Rory D. Cosgrove
WDTL President