August 8, 2025

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

CC: David Forte, Senior Policy Advisor

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 concerning minimum standards for P&C claims handling in Washington state.

In the spirit of continuing the dialogue initiated by the OIC in the prepublication draft and interested party process, the National Association of Mutual Insurance Companies (NAMIC), the American Property Casualty Insurance Association (APCIA), and the Northwest Insurance Council ("the trades") have reviewed the draft amendments with our member companies, and we respectfully offer the following observations, inquiries and initial recommendations:

WAC 284-30-300 – Authority and Purpose

The language "with such frequency as to indicate a general business practice" is proposed to be deleted. This revision creates an unreasonably low standard for violations, in which *any* error or deviation from strict compliance is an infraction that exposes an insurer to potential penalties as well as a potential claim under the Insurance Fair Conduct Act. This creates an unfair standard of perfection in a regulatory framework intended to promote compliance. Claims practices are performed by humans and humans will invariably make mistakes that may not impact the outcome of the claim.

WAC 284-30-320 – Definitions

Our members provided feedback that the language used throughout this section was ambiguous and incorporated several terms that were left undefined. This uncertainty creates several questions around the definitions provided and these are summarized below in the following subsections:

> **(2) "Claim"**
> The language differentiating "claims" from "inquiries" would benefit from clearer definitions of each term. Regarding communications that establish either a claim or an inquiry, to whom must the communication be made? What form must the communication take? It is also important to note, particularly without clearer definitional distinctions, what may look like an inquiry from an insured can suggest that damage or loss has been

incurred, which can affect the insured property in a future claim or in a case of diminished insurable value.

(10) "Insurance Policy or "Insurance Contract"
We are aware that this language is unchanged from current code. However, this existing language is problematic as there would not be a contract until the policy is issued. The use of the "intended for issuance" language is unclear – if not issued, a policy would not be binding.

(11) "Insurer"
The inclusion of "any individual" in the existing definition suggests that a representative of the company could be held liable in bad faith actions.

(12) "Investigation"
In the existing language, what is implied by "indirectly" investigating a claim? Why is the calculation of amounts owed now included in the definition of "investigation?" It is appropriate to distinguish the investigation of a claim from the evaluation and adjustment of a claim.

(15) "Notification of claim"
What is a 'legally liable party?' What if the 'legally liable party' does not tell their insurer about the loss? The language used suggests that notice to the insured is notice to the insurance company. What if a 'legally liable party' doesn't know or believe that they are liable? What if a party isn't in fact legally liable? The term 'representative' needs to be defined and clarified to indicate who can provide notification and the duties owed by the insurer, depending on who provided the notice.

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

(4) What is an 'individual assessment' as used within this section? What is considered to be a 'database?' What is considered a "refusal"? Some might characterize an insurer asking questions as a "refusal" when more information is needed.

(5) Eliminating 'proof of loss' language and replacing it with "receiving notification of claim" is problematic. Often ,a decision on coverage cannot be made until proof of loss requirements have been met by the claimant. The language proposed in the draft rule imposes a duty on insurers to affirm or deny coverage before the necessary documentation has been provided, and in many cases, likely before a claim can be meaningfully evaluated .

(11) This amendment expands the language to include third-party claimants. Third-party claimants do not have a contractual duty to provide documentation. This also places the burden on insurers to justify why a specific document or set of records is needed to proceed with a given claim.

(14) This provision is concerning as it appears to equip public adjusters with the same authority level as the named insured, which will in turn broaden disclosure obligations and create operational, legal, and privacy risks. This amendment equates public adjusters with attorneys in terms of their authority to receive sensitive documents and make representations. The phrase

"pertinent claim information and insurance policy" is overly broad and may conflict with work product protections.

(15)(16) The change to three business days from the prior language of three working days raises concern as this could reduce the time for the insurer to comply. Is it OIC's determination that "business days" and "working days" are the same? If not, can a definition of 'business day' be included?

Subsections related to emergency mitigation (Subsections 20-23)

The trades are aware that the OIC's intent in these subsections is to improve timeliness and response from insurers to prevent additional damage to the insured's property, lead to damage that is not a covered peril under a policy or may result in ineffective or elusive repair work that spends limited policy resources without resolving damage claims. Our members have raised significant concerns with the language of these sections as currently drafted; however, we believe further dialog between the industry and the OIC could aid in developing clear standards for insurers and insureds. Here are concerns insurers have identified so far.

(20) This provision seems to open the door for the insurer having to accept *any* "emergency mitigation" charges. It appears to be a strict requirement to pay the invoice, regardless of whether it is reasonable or necessary and could result in abuse and predatory practices. This subsection needs more definition and clarification to outline the duties owed by the insurer. As written, this section eliminates the insurers' ability to reasonably evaluate and/or contest emergency mitigation invoices that are excessive, unrelated. or unsupported. Furthermore, as currently written, this provision could be interpreted to require insurers to pay mitigation claims regardless of whether or not the loss is a covered peril.

(21) Relates to adding a 3-business day limit to approve or reject the first-party claimant's scope of non-emergency mitigation. The primary concern with this language is that our members believe three days to be too short of a timeframe. As written, this could have the unintended consequence of incomplete, excessive invoices being submitted and making it difficult for insurers to respond within three days, resulting in a violation.

(22) This section would prohibit the insurer from requiring an appraiser to adjust their valuation of the loss. The language is of concern because it is not clear on what is being addressed. What if an error occurred or the appraiser used the wrong methodology in their valuation? The insurer just has to accept it ? The language is unclear and seems to prevent insurers from negotiating with appraisers under the appraisal clause to revise or adjust valuations once the appraiser's valuation is submitted.

(23) We are unclear what a 'specialty consumer reporting company' is referencing as there is not a definition provided in this section. The use of 'negligently' creates concern as this could include inadvertent system errors, data mismatches, incorrect coding of coverage denials, misidentifying a loss as at fault vs not at fault, etc. The language used creates an exposure to where any number of "reporting" violations could be alleged to have hindered a consumer's "ability to obtain insurance." because it is undefined and subjective.

WAC 284-30-340 – File and record documentation

(2) There are many concerns raised over this section. The language used is overly broad and members have expressed concerns around the need to protect privacy of other parties, medical records, and other personally identifying information. Some documents would be prohibited from disclosure via regulations or contract as well, and many documents would be considered the internal work product of our member companies. The limitation of only 15 business days could be excessively restrictive in certain cases as well.

WAC 284-30-350 – Misrepresentation of policy provisions

Much like 284-30-300, the primary concern here again is that a single error is deemed to be a violation that could expose an insurer to a claim under the Insurance Fair Conduct Act.

(4) Insurers need the ability to provide a reasonable timeframe for submitting proof of loss. Claimants would be subject to pertinent statutes of limitations. This reads as though a claimant would not be bound by any time restriction.

WAC 284-30-360 – Standards of the insurer to acknowledge pertinent communications

(1) Instead of allowing 10 working days to respond to acknowledge receiving notification of a claim, this change requires only 5 business days to acknowledge, which our members believe to be too short of a timeframe. To whom is the insurer required to acknowledge receiving notification of the claim? It can often require several days to determine the name and address of drivers, passengers, registered owners, etc., and connecting with all parties to a claim within this timeframe could be problematic. The language does not allow for exceptions to creating strict liability even if timelines need extensions due to natural disasters, volume surges, or other complexities.

(2) Instead of allowing an insurer 15 working days to respond to an OIC complaint, this section reduces insurer response time to 10 business days. Our members feel this should remain at 15 working days as adequate time is needed to conduct an internal review and formulate the correct response to the OIC.

(3) Instead of allowing an insurer 10 working days to appropriately reply to pertinent communications from a claimant, this provision changes it to 5 business days. Similar to (2) above, our members request to maintain the 10-working day requirement in place because an appropriate response could take several days to formulate.

WAC 284-30-370 – Standards for prompt investigation of a claim

(1a) Given the proposed update to the definition for the term "investigation," the 30-day time requirement is not reasonable, especially with respect to traditionally longer-tail claims. Additionally, member concern is that this iterative 30-day requirement creates an unnecessary burden to where unnecessary correspondence is being generated.

(i)(iA)(iB)(iC)(iD) This list is highly prescriptive and requiring a summary of decisions within a delay notice is not appropriate. (iA) and (iB) are out of place as these requirements will not be known until the investigation is completed or while the insurer is still waiting on additional information.

Furthermore, there is no extension mechanism, even if the delay is caused by a claimant's unresponsiveness.

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

(1) While it is favorable that the amount of time is increased from 15 to 30 calendar days, the change of the standard from "proof of loss," to "notification of a claim" is problematic, because notification of a claim does not usually give an insurer all of the information it needs to determine whether to accept or deny a claim.

(3) As we've stated elsewhere in our comments, we are concerned with the expansion of application of this subsection to 3rd parties. Additionally, this section appears to be referring to specific policy language related to proof of loss, a first-party matter only. This provision will create the need for insurers to send out unnecessary delay letters in scenarios where nothing has changed in the course of the claim.

(7) The proposed draft has removed the current reference to "actual cash value" and replaced it with a broader obligation that the insurer is responsible for the "accuracy of the evaluation to determine the amount owed under the applicable insurance policy." "Accuracy" is undefined, which could lead to enforcement actions if market prices increase after the estimate is created or if the claimant secures a higher bid.

(8) This section is unclear as to whether the term "database" is to include the use of vehicle repair estimating systems. If so, detailing the estimating system could be expensive and burdensome, further increasing the cost of claim adjudication. These details could also be proprietary by the owner of the estimating system.

WAC 284-30-390 – Acts or practices considered unfair in the settlement of motor vehicle claims

(1) This section greatly expands the requirements for a physical inspection, which will delay claims settlements, increase loss adjustment expenses, and ultimately impact premiums. Virtual estimating has been employed throughout the industry and offers the advantages of improved efficiency and speed, reduced costs, and enhanced customer experience.

Subsection (a)(i) requires the insurer to receive authorization from the claimant to use a photo estimating process prior to use. Why is it necessary to obtain pre-authorization? If a claimant knows they have access to that process and choose to use it, is that not evidence that they are allowing that process to be used by the insurer? If not, could this requirement be met by a statement included in the photo estimating app or claim form that states that use of photo estimating app by the claimant automatically implies they are granting permission for the insurer to accept the claim via the app (that could also possibly include the required disclosure that an insured has the right to request an in-person inspection)?

(A)(iii) The five-business day inspection requirement to respond to a claimant's request for physical inspection may not be reasonable in all cases. Additionally, who owns the responsibility for determining that a vehicle is not safe to operate?

(b)(i) The requirement for citing relevant policy language can be difficult when it comes to specifics. Laying out the specifics of how typical industry rates are determined will be burdensome. An insurance auto policy does not detail every element of repair consideration and cost and the concern around this requirement is that it will stall claim handling processes and create unnecessary disputes. Members also cited concerns that the 3-day requirement is too short.

(b)(iv) This requirement is perceived to be unrealistic and could cause further delay the claim adjusting process. The repair facility is not a party to the claim; a requirement to include them on every communication throughout the claim is not needed. Furthermore, it is appropriate at times to communicate directly with the repair facility, without the need for the claimant to be involved in the communication.

(b)(v) Three days is insufficient for this requirement. If the insurer is not able to speak with the shop, they cannot be informed about how much the storage charges are or whether it is even being incurred. As written, this would enable a repair shop to evade contact with an insurer , then charge $500 a day for storage and the insurer would be unable to challenge the charge because they didn't know and weren't able to advise the insured.

(2) The language used in this section is unclear. There is not a definition provided for 'photo based estimating process,' 'virtual inspection process,' 'supplemental damage estimate,' 'final invoice,' or 'internet-based application.' A specific reason for why an insurer may offer less than the amount of a claimant's estimate is likely not to be included within the policy language.

(4) This language expands the current requirement to provide a copy of its repair estimate to the claimant, to set "competency" requirements for the person the insurer has prepare the estimate and making the insurer responsible for the accuracy of their estimate. These seem like obvious qualities that an insurer would want from their estimators, but it opens the door to shops challenging credentials, with no such reciprocal obligation made of the shop.

WAC 284-30-391 – Methods and standards of practice for settlement of total loss vehicle claims

(2)(i) This section adds a requirement for comparable vehicles to be within a 150-mile range. This may be problematic as certain models, aged vehicles may simply not be available within a 150-mile range. However, given that current language continued in other subsections also refers to a 150-mile range, we would urge the OIC to consider including language that provides an option for the insurer to meet the requirements of this section if a comparable vehicle cannot be identified within that range.

(6b) The language of this section is highly confusing. It seems to suggest that if the claimant has not adhered to the appraisal process, the insurer must reopen their claim and reevaluate the vehicle valuation. This effectively negates the purpose of the appraisal clause. In addition, changing the language from "reasonable" steps to "necessary" steps creates greater burden on the insurer, but it's difficult to know what the burden is – presumably something more than reasonable. This section is very unclear to our members.

(7) The language of this subsection is difficult to interpret. However, it appears to say that if rental coverage is in place, the insurer must provide rental for at least 10 calendar days, which we believe

is longer than current industry averages. Further, members questioned whether this particular requirement exceeds the OIC's regulatory authority, as it appears to establish insurance policy limits in the code, establishing a minimum benefit level for a line of coverage. Can the OIC provide some additional background regarding this requirement, what is intended and a statutory citation that permits it to be included in the rule?

WAC 284-30-392 – Information that must be included in the insurer's total loss vehicle valuation report

(4) This provision introduces requirements that the insurer must provide supporting information regarding a comparable vehicle's condition. For the total loss vehicle, the insurer must provide supporting photographs and documentation to demonstrate its determination of the condition. The trades suggest this information should be provided by an insurer only 'upon request' so as to otherwise not create a costly administrative burden on the insurer.

Our organizations and our respective members value our ongoing discussion with the Commissioner and OIC staff and appreciate the opportunity to offer this feedback. While this correspondence has largely been focused on identifying concerns, we would appreciate additional time and opportunity to share thoughts and ideas regarding specific language recommendations to improve and clarify the proposed rules. We look forward to continued dialogue as this pre-rulemaking process continues.

Respectfully,

Mark Sektnan
VP, State Gov't Relations
APCIA
916.449.1370
mark.sektnan@apci.org

Kenton Brine,
President
NWIC
360.481.6539
kenton.brine@nwinsurance.org

Brandon Vick
VP, State Gov't Relations
Pacific NW Region, NAMIC
360.609.4363
bvick@namic.org