OIC Rules Coordinator

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To: OIC Rules Coordinator
Subject: R2025-05 First Prepublication draft comment

External Email

Commissioner Kuderer:

I am providing comment regarding R2025-05 First Publication related to minimum standard of reclaims handling and the strong support for measures and language in that version, and my encouragement for the OIC to move forward in formally adopting these changes.

I would first underscore the importance that these proposed changes are addressing the *minimum standard for claims handling*, which itself speaks to the fact that the practices and tactics carriers need the lowest-threshold, minimum standard expectation to be so clearly defined. History and experience reflect that without such clarity, those that are affected by insurer unilateral and self-serving determinations would be left at a distinct disadvantage, typically with far fewer resources to fight for what is right against such insurer practices. In my mind, it is really a shame we need to have define the "minimum standard," instead of the industry functioning at a much higher standard and level of transparency. I also think it is interesting when there are those on the insurance side that will fight against rules about what the minimum sanded should be, signaling the intent to want that standard to be even lower.

The R2025-05 document version makes significant and appropriate clarifications, language of which should remain in this minimum standard clarification going forward to finalization of the formal Rule. This would include:

- WAC 284-30-320 (12), which proposes that the definition of investigations includes issues related to determinations of amounts owed.
- WAC 284-30-330 (4), which includes and exception of a "reasonable investigation" before claim denial or refusal. This language also importantly prohibits exclusive use of databases in these determinations, which is important because historically insurers have refused claims citing nebulous database determinations and nothing more. These database applications also often come from third party vendors used by insurers, which further complicates the ability to understand or determine how insure decisions were ultimately made. I would encourage additional language related to insurers or their venders maintaining a record of their investigative process, and how database information was weighted and used in the ultimate decision to deny or refuse a claim, which should eb made available upon request by insurers or health care provider. Historically, insurers have never provided such information. Further, there should be added rule language that in the event that a third party vender is used in make a claim decision, the ultimate responsibility to maintain and provide information related to claims decision-making, investigation, and database sue is the responsibility of the insurer, and the insurer cannot shift that responsibility to a third party vender.

- WAC 284-30-340 (2): This section should specifically add language that extends this requirement to third party venders, and related to database use, including AI use activities.
- WAC 284-30-380 (8): This section (our some other applicable section) need to specifically include language related to database information (including AI uses) disclosure related to health care cost decisions and payments, including denial or refusal, and extending these requirements to third party venders being sued by the insurers.

It is important for your office to understand that insurers are already applying and abusing the application of nebulous and ill-defined "database" information to refuse/deny/or reduce claims arbitrarily, and without any meaningful supportive information to even be able to address with a counter response. This had been going on for years. Patients and providers (especially single-provider or small-group practices) don't come close to having the resources that insurers do, and are left at the mercy of the insurer to do as they please. Requests to insurers for disclosures of any specific information supporting denials or payment reductions about how database information was obtained or applied have gone unanswered. Patients and injuries parties are left to pick up the difference, or providers already left to just write these balances off. Insurers have historically also hidden under a veil of a relationship with a third party vender they contract weight, and triangulate responsibility and communication between those venders and doctors/patients, further frustrating full and clear disclosure and transparency. All of this is the direct detriment and harm to patients/injured parties, provides, and the overall Washington public more generally.

I an insured is going attempt to superseded decisions made by the health care providers having direct contact with patients/injured parties, and making related health care decisions based on that dire contact, or reduce appropriate payment for services rendered on that basis, using databases, AI, or third party venders to do so, there should be full clear disclosure and transparency related to that.

I would lastly highlight that it has been the experience of my ofifce for quite some time, and showing a pattern of increased frequency more recently, that front-line claims decisions are not even being made by a human, and we have been told by insurers that the claim will only get to the level os an actual human review upon appeal, with a significant delay added to get through that appeal process. This is just completely unfair to health care providers and the patients they serve.

These Rule revisions and clarifications are strongly needed.

Please feel free to reach out to me with any questions or concerns. Thank you your time.

Respectfully,

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