



February 3, 2026

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

CC: OIC Rules Coordinator
David Forte, Senior Policy Advisor

RE: Comments on R 2025-05 – Clarifying and updating the minimum standards for claims handling, Prepublication Draft 3

Submitted via email.

Dear Commissioner Kuderer,

Thank you for the opportunity to submit comments on the **third prepublication draft** of proposed amendments 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.

Similar to the method used by the OIC to highlight differences from the second draft to the third, we have amended our previous comment letter and will show these additions/changes in **highlighted text**.

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.

We further note that the NAIC’s Unfair Claims Settlement Practices Act model relies on the “general business practice” standard as a guardrail, and that framework has been adopted by the majority of states. Eliminating this language significantly expands regulatory exposure for one-off errors and undermines both predictability and fairness in enforcement, contrary to longstanding NAIC guidance.

Repeated concern: As no changes appear to have been made in this section from previous drafts, the trades continue to register our deep concern regarding the inclusion of this language in the third prepublication draft. We respectfully request this language be omitted and the language of the current, unamended rule be retained.

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"

We acknowledge and do not have comments regarding the deletion of the proposed definition of "Claim" in subsection (1).

(11) "Investigation"

Repeated concern: 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?" Is it appropriate to distinguish the investigation of a claim from the evaluation and adjustment of a claim?

(19) Our members have identified additional concerns regarding the new proposed definition of "undisputed amount."

1. The definition improperly converts an insurer's preliminary evaluation into an "acknowledged minimum owed." An insurer's initial number is a working estimate, not an admission. A claim can involve multiple components, some clearly owed and some legitimately disputed.
2. On the other side this definition treats the consumer's current evaluation or demand as an "acknowledged minimum owed" encouraging strategic inflation of demands and increases in supplements. This increases friction between an insurer and their policyholder, with the agent likely in the middle. Claims will be reopened which unnecessarily prolongs ultimate resolution and closure of claims.
3. This definition conflicts with common claims workflows in which amounts are not "owed" until certain policy conditions are met. Even where coverage exists, some payments depend on documentation, proof of loss, scope of agreement or policy conditions. Also the claims process is very fluid, and initial payment may not be possible when an amount is demanded because there may be outstanding issues around coverage, causation, pricing, depreciation, and or limits.

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

(4) Repeated concern (no changes from previous draft): 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.

Repeated concern (no change from previous draft): The trades acknowledge and appreciate the clarifying language and addition of “reasonable” to this subsection. However, we remain concerned that the intent of the language does not provide sufficient clarity for compliance by insurers. Insurers frequently use multiple data sources/databases that aid in and speed the claims process: replacement cost estimating programs, photo databases that show preexisting damages; databases that can help determine the overall health of a roof are some examples. The concept of not relying solely on this information is straightforward enough, but what weight can be applied from these sources is less clear.

(5) Repeated concern (no change from previous draft): 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) Repeated concern (no change from previous draft): 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) Repeated concern (no change from previous draft): 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.

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) Repeated concern (no change from previous draft): 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.

The trades acknowledge and appreciate the changes made by the OIC in the second draft of subsection 20, including extending the initially proposed 3-day time limit for response to a claimant's scope of mitigation to five days. Our members continue to suggest, however, that in the case of complex claims, or in the case of a large-scale disaster that stretches insurer resources, an insurer may need additional time. **Ten business days has been suggested as the response time limit.** There may be other ways to address this issue as well, such as allowing a longer response time under special and identified circumstances.

(20)(b): The trades acknowledge and appreciate the proposed deletion of subsection (20)(b).

(23) New concern: The trades and our members have significant concerns/objections regarding this subsection, as it is tied to the problematic definition of "undisputed amount" proposed in WAC 284-30-320. (Please see our comments above referencing that section.) We further note our concern that adding this language in subsection (23) could result in prohibiting or mislabeling standard, accepted claims handling practices as misconduct. We respectfully request that this subsection be omitted.

WAC 284-30-340 – File and record documentation

(2) Repeated concerns. 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, and longer response times are typically allowed by the courts.**

The trades acknowledge and appreciate the changes and additions made to subsection (2) in the second prepublication draft by the OIC. However, we and our members continue to have significant concerns about the requirements in this subsection. The requirement to provide all written reports and claim notes on request from a first party claimant is concerning.

Insurers tell us that when a first party claimant asks for the claim file, it's typically to challenge either the coverage decision or the amount of the claim payment. The coverage letter, estimate, expert reports, diagrams, and photographs are typically sufficient to provide the policyholder with all the information necessary to challenge coverage and damages. The "claim notes" are typically internal conversations and thought processes that do not change the final conclusions in the coverage letter and claim payment. Mandating providing the claim notes could easily be used by an insured out of context, to pick apart the entire claim process and demand detailed responses to every step in the claims process. An unintended consequence may be that claim adjusters will simply pare down their claim notes, which could delay claims settlements. We urge the OIC to reconsider these requirements.

We would, however, like to acknowledge with appreciation the new deletion of the reference in subsection (2)(a) to providing a log with specifics and reasoning regarding withheld information. Unfortunately, the entirety of subsection (2) remains of concern to the trades and our members.

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.

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

(2) (repeated concerns; no changes noted from the previous draft) 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.

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

(1)(a) (Repeated concern; no change noted from previous draft.) 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.

The trades acknowledge and appreciate the changes made to this section in the second draft, however, we continue to request that this section apply exclusively to **first party claims**.

Also, while the trades acknowledge the language additions made in subsection (1)(b), we continue to respectfully request that additional written notice only be required every **45 business days** instead of the current "every 30 days" in the draft, in order to allow insurers more time to obtain needed information from the claimant or providers/vendors assisting the claimant. Allowing this additional time in these unique circumstances will allow the insurer to focus on the substantive work of the claims investigation and less time on sending letters explaining delays.

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

(1) While it is favorable that the amount of time was increased in the second draft 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.

We and our members continue to be concerned, however, that the requirements of revised subsection (8) may be difficult or impossible for insurers to comply with. Some of the data that insurers use from vendors may be not be available and may be considered confidential and proprietary by the vendors.

Further, the trades are concerned that the new language in prepublication draft three, in subsection (8), which adds, “when either party disagrees on cost to repair or replace” will create additional “pain points” and add unnecessary disclosure requirements that worsen – not improve – the claims experience for consumers. We respectfully request this additional language be omitted.

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

The trades acknowledge the changes made in the third prepublication draft, but wish to restate concerns previously raised with regard to this section.

(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.

(b)(vi) The trades acknowledge and appreciate the clarification made in subsection (1)(b)(vi) limiting the disclosure requirements to **first-party** claimants.

Further, a disclosure of this information to a claimant should be required within five business days **after the insurer has confirmed coverage**, not from the date that the claim is received.

(4)(a) The trades acknowledge and appreciate the clarification including an employee of the insurer as a "competent person" to meet the requirements of this subsection.

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 trades acknowledge and appreciate the changes made to this subsection in the third prepublication draft. We respectfully request that the reference in this subsection to changed from 7 calendar days to 7 **business** days.

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.

The trades acknowledge and appreciate the change made in the second prepublication draft in subsection (4)(d) of this section adding “**Upon request from the claimant**” prior to an insurer being required to provide additional information regarding comparable motor vehicles. However, we continue to hear concerns expressed about the requirements of this entire section, and we hope that the OIC will consider having direct discussions with the trades, insurers and vendors to add clarity to WAC 284-30-392.

WAC 284-30-394: The third prepublication draft expands this WAC to apply to phone call documentation to **ALL** claimants, not just first-party claimants. In practice, we are told that adjusters rely on quick phone calls to efficiently resolve issues, clarify facts and move claims forward. But the changes in this section impose a rigid, technical file documentation protocol (date, time, name, and summary of conversation” on routine claim communications increasing the administrative burden on insurers.

The trades wish to acknowledge and thank the Commissioner and the OIC policy team for their continuing work on this complex proposed rulemaking. We appreciate the efforts made to consider our previous comments and our members' concerns, and we look forward to further engagement between your office and the P&C industry to further improve the proposed rules. We may also identify additional concerns and hope to share those with you during the development of what we hope will be a new prepublication draft issued prior to rulemaking.

Respectfully,

Mark Sektan
VP, State Gov't Relations
APCIA
916.449.1370
mark.sektan@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