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No. 94771-6

IN WASHINGTON STATE SUPREME COURT

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BRETT DURANT, on behalf of himself and all other similarly situated,

Plaintiffs,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,  
a foreign automobile insurance company,

Defendant.

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ON QUESTIONS CERTIFIED BY THE  
UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
HONORABLE RICHARD A. JONES  
CASE NO. 2:15-CV-01710-RAJ

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**DEFENDANT STATE FARM'S ANSWER TO BRIEF OF *AMICUS CURIAE*  
WASHINGTON STATE INSURANCE COMMISSIONER MIKE KREIDLER**

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## I. INTRODUCTION

The Amicus Curiae Brief filed by Washington State Insurance Commissioner Mike Kreidler (the “Commissioner”) argues a new interpretation of WAC 284-30-395(1) that conflicts with the views of the prior Commissioner and his own staff.

The new evidence offered with the Commissioner’s Brief demonstrates that dichotomy. While this Commissioner asserts that WAC 284-30-395(1) was intended to “clarify” the statutory limitations for PIP coverage, the prior Commissioner disclaimed that the regulation any way changed the statutory limitations on PIP coverage. (Commissioner’s Brief, Appx. A). That Commissioner believed that RCW 48.22.005(7) – *not* WAC 284-30-395(1) – governed the scope of PIP coverage.

The prior Commissioner’s office also compelled State Farm to define “necessary” in its policy form, and specifically approved its definition in terms of MMI *after* the Legislature adopted RCW 48.22.005(7)’s “necessary” standard. In 2006, long after the implementation of WAC 284-30-395, this Commissioner’s office again approved State Farm’s “necessary” definition. Consistent with that approval, the Commissioner’s Legal Department opined *in 2016* that State Farm’s policy form complied with WAC 284-30-395(1).

To the extent the Commissioner now contends that State Farm's policy form violates WAC 284-30-395(1) or RCW 48.22.005(7)'s "necessary" standard, that amounts to a revised agency interpretation that should be afforded no deference under Washington law.

The Commissioner's view is also internally inconsistent. The Commissioner argues that MMI both violates and is consistent with the statutory "necessary" standard, and that "necessary" both can and cannot be defined in terms of MMI in the PIP context. Accepting this circular view would violate the first fundamental tenet of due process: that a law give fair notice of what conduct violates it.

The Commissioner also urges a "broad" interpretation of "necessary," while ignoring that "necessary" is a restrictive term, not an expansive one. Broadly interpreting "necessary" would simply read it out of the statute, which basic rules of statutory construction forbid.

The Commissioner argues that defining necessary in terms of MMI would render PIP coverage illusory, while ignoring that Plaintiff's own claim disproves that assertion. State Farm paid about \$20,000 on Plaintiff's PIP claim before his chiropractor advised he had reached MMI, and continued paying for non-chiropractic services thereafter.

The Commissioner's position also contradicts the express terms of WAC 284-30-395(1), which has no application to benefits termination

decisions. All that Subsection (1) of the regulation requires is that an insurer send a benefits disclosure letter, which everyone agrees State Farm did here. Subsection (2) of the regulation applies when benefits are terminated, and only requires an insurer to explain its determination that medical expenses were not “necessary,” while in no way directing or restricting what factors an insurer should consider in making that determination. WAC 284-30-395(2). An insurer violates Subsection (2) if it terminates benefits simply by stating that further treatment is not “necessary.” The Commissioner ignores Subsection (2), but this Court should not. Because the Commissioner’s current view supports the absurd result of an insurer being held liable for violating Subsection (1) by complying with Subsection (2), it fails.

Finally, the Commissioner offers no competing definition of “necessary,” a term that RCW 48.22.005(7) and WAC 284-30-395(1) also fail to define. If the Commissioner believes that the statutory “necessary” standard needs clarification, then his office should engage in formal rulemaking or agency action on the issue to ensure that all interested parties are afforded due process and adequate notice. The Court should require the Commissioner to follow that process, rather than accept his new, and strained, interpretation of an unchanged law and regulation.

**II.**  
**THE COMMISSIONER’S CURRENT INTERPRETATION  
OF WAC 284-30-395(1) CONFLICTS  
WITH THE PRIOR COMMISSIONER’S**

The Commissioner contends that the prior Commissioner promulgated WAC 284-30-395(1) to “clarify” PIP coverage and “establish[] the only grounds carriers are permitted to use for denying, limiting or terminating medical and hospital coverage provided as part of PIP insurance.” (Commissioner’s Brief, p. 1, 4-5). However, the Concise Explanatory Statement (“CES”) offered as support for that assertion does not say that. (Commissioner’s Brief, Appx. A).

The CES affirmatively disclaims that WAC 284-30-395(1) has *any* impact on the statutory bases to limit PIP benefits set forth in RCW 48.22.005(7). In response to a public comment asserting that WAC 284-30-395(1)’s “list of possible reasons for denial is confusing” because it does not address policy limits and other issues, the prior Commissioner explained:

*“The list reiterates the statutory reasons to limit benefits.  
Contractual reasons may apply as well.”*

(Commissioner’s Brief, Appx. A, Att. A to CES, p. 5)(emphasis added).

In response to another comment suggesting that WAC 284-30-395(1) should require PIP insurers to pre-authorize procedures, the prior Commissioner wrote:

“Generally, PIP benefits do not require ‘pre-authorization’ and *any requirement for a change in PIP benefits is appropriate for review by the Legislature.*”

(Commissioner’s Brief, Appx. A, Att. A. to CES, p. 4). Indeed, Washington law prohibits the Commissioner from promulgating any rule changing the legislatively-mandated requirements for PIP coverage. *Edelman v. State x rel. P.D.C.*, 152 Wn.2d 584, 591, 99 P.3d 386 (2004) (“An agency may not promulgate a rule that amends or changes a legislative enactment.”).

The prior Commissioner went on to explain the intent of WAC 284-30-395(1) as follows:

“The goal of the rule is a better educated consumer.”

“Based on the Commissioner’s review of consumer complaints and conversations with insurers, it is clear that a *disclosure requirement* is an appropriate remedy for the confusion policyholders exhibits.”

“This rule is *intended to provide adequate disclosure of policy provisions and limitations* at time of claim, when the information is most valuable. *The rule is not intended to change the terms of an insurance contract.*”

(Commissioner’s Brief, Appx. A, Att. A. to CES, pp. 2-4) (emphasis added). This is consistent with State Farm’s discussion in its main brief detailing how Subsection (1) of WAC 284-30-395 functions as a disclosure requirement, while Subsection (2) of the regulation applies to a decision to terminate benefits. (State Farm’s Brief, pp. 11-12).

Subsection (2) requires an insurer to “explain” the basis of any determination that medical expenses were not “necessary,” but in no way directs or restricts what factors an insurer should consider in making that determination. WAC 284-30-395(2).

In sum, the CES underscores that, contrary to the Commissioner’s current suggestion, *nothing* in the regulation changes the statutory “necessary” standard adopted in RCW 48.22.005(7), or identifies what factors insurers should consider in making a “not necessary” determination.<sup>1</sup>

### **III. THE COMMISSIONER’S CURRENT VIEW OF STATE FARM’S POLICY FORM CONFLICTS WITH HIS OFFICE’S PRIOR ONES**

The Commissioner also contends that a carrier cannot, consistent with RCW 48.22.005(7), structure their PIP coverage to allow “use of [MMI] as an additional basis for the denial of claims” separate and apart from the “necessary” ground. (Commissioner’s Brief, p. 1). To the extent

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<sup>1</sup> The CES also characterizes WAC 284-30-395 as an “interpretive rule,” not a legislative one. (Commissioner’s Brief, Exh. A, Att. A to CES, p. 3). “Interpretive rules ... are not binding on the courts at all ....” *Association of Wash. Bus. v. Dep’t of Revenue*, 155 Wn.2d 430, 447, 120 P.3d 46 (2005). As the Court has explained: “[Interpretive rules] are afforded no deference other than the power of persuasion. Accuracy and logic are the only clout interpretive rules yield.” *Id.* at 447.

the Commissioner now contends that State Farm's form does this, that conflicts with his office's prior views. The undisputed record demonstrates that the offices of both the prior Commissioner, and this one, previously found State Farm's policy form *consistent* with the "necessary" standard.

As State Farm detailed in its main brief, the auto policy form it originally submitted to the prior Commissioner for approval in 1992 provided coverage for "necessary" medical expenses, and did not mention MMI. (State Farm's Brief, pp. 7-8; Dkt. 7-7, pp. 6-7, 9-10). That Commissioner's office rejected State Farm's form, and refused to approve it until State Farm defined "necessary." (State Farm's Brief, pp. 7-9; Dkt. 7-7, pp. 15-40). In 1994, *after* the Legislature adopted RCW 48.22.005(7)'s "necessary" standard, that Commissioner's office specifically approved State Farm's "necessary" definition in terms of MMI.<sup>2</sup> (State Farm's Brief, pp. 9-10; Dkt. 7-7, p. 46; Dkt. 7-8, p. 11).

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<sup>2</sup> Thus, the record shows that State Farm only defined "necessary" after the prior Commissioner compelled it to. (Dkt. 7-7, pp. 6-46; Dkt. 7-8, p. 11). This was not an insurer attempting to avoid statutorily mandated coverage – it was an insurer wanting to defer to the statutory "necessary" standard and being compelled by the Commissioner to define that standard in its policy form. (*Id.*).

The Commissioner suggests that the 1994 approval should be disregarded because it came before the prior Commissioner implemented WAC 284-30-395. (Commissioner's Brief, p. 5). That fails because, as the CES shows, the statute, not the regulation, imposes the "necessary" standard. (Commissioner's Brief, Appx. A, Att. A, pp. 2-4). The Commissioner acknowledges that the Legislature adopted the statutory "necessary" standard in 1993, well before the 1994 approval of State Farm's "necessary" definition. (Commissioner's Brief, p. 4); *Dot Foods, Inc. v. Dep't of Revenue*, 166 Wn.2d 912, 921, 215 P.3d 185 (2009) (a regulator is presumably aware of the legislature's intent to adopt a law falling within the regulator's authority). Indeed, the letter approving State Farm's "necessary" definition in terms of MMI specifically referenced RCW 48.22.005. (Dkt. 7-8, p. 11 of 58).

Then in 2006, nine years after WAC 284-30-395 went into effect, *this* Commissioner's office approved State Farm's policy form defining "necessary" in terms of MMI. (Dkt. 7-6, p. 55; Dkt. 7-8, p. 58; Dkt. 39-1, p. 24; State Farm's Brief, Exhs. 3-4). The Commissioner attempts to downplay that approval as well, by disclaiming that it involved "review" of the MMI language. (Commissioner's Brief, p. 5). The Commissioner offers no evidence to support that claim, and the undisputed record shows otherwise.

The Commissioner's office initially disapproved numerous provisions of State Farm's policy form in 2006, including Subsection (1)(b) of the PIP definition of "reasonable medical expenses," which defined the term "reasonable." (State Farm's Brief, Exh. 4). The "necessary" definition, including the subject MMI language, appeared in Subsection (2) of that same definition. (State Farm's Brief, Exh. 3). It defies logic to assume that the Commissioner's 2006 review involved only one part of the "reasonable medical expenses" definition and not the other, especially since that definition involved the scope of PIP coverage granted to Washington consumers.

The record also negates the Commissioner's suggestion that State Farm knew or should have known his office's current view as of July 2015, when it received a letter from Rates & Forms staff member, Alan Hudina. Plaintiff's counsel solicited that letter, and no evidence supports that the Commissioner or his Legal Department knew or approved of Mr. Hudina's letter before it was sent. (Commissioner's Brief, p. 5).

The evidence does show, however, that *after* learning of Mr. Hudina's letter, the Commissioner referred the issue of whether State Farm's "necessary" definition complied with WAC 284-30-395 (1) to his Legal Department. (Dkt. 71, 74-1). In September 2016, the Commissioner's Legal Department opined "that the State Farm contract

language does *not* violate the WAC provision and is consistent with the ‘not necessary’ denial basis in WAC 284-30-395(1)(b).” (Dkt. 74-1, pp. 2-3)(emphasis added). One month after that, the Commissioner’s office advised State Farm that it was closing a Market Conduct Continuum Action regarding State Farm’s policy form compliance with WAC 284-30-395, without regulatory action. (Dkt. 61). Consistent with that conduct, in April 2017, the Commissioner confirmed through counsel that his office had still not taken any agency action on the policy form issue, and that the matter was under review by his Legal Department. (Dkt. 71, 73); RCW 34.05.010 (defining “agency action” to include “enforcement of a statute” or “application of an agency rule”). Thus, representations by the Commissioner’s office since July 2015 negated, rather than supported, that Mr. Hudina’s letter reflected the Commissioner’s actual, and final, position on the issue.

But regardless of whether the Commissioner reached his current view in 2015 or 2018, the critical fact is that the current view conflicts with the historical views of his office (including his Legal Department’s 2016 opinion).

**IV.**  
**THIS COMMISSIONER’S CURRENT CONFLICTING VIEW  
IS NOT ENTITLED TO ANY DEFERENCE**

Because of that conflict within the Commissioner’s office, the Commissioner’s current view is not entitled to any deference here. As State Farm noted in its main brief, this Court affords no deference to an agency’s changed interpretation of an unchanged statute it administers. (State Farm’s Brief, p. 32, fn. 14) (citing *Dot Foods, Inc. v. Dep’t of Revenue*, 166 Wn.2d 912, 921, 215 P.3d 185 (2009)).

*Dot Foods* involved a challenge to the Washington Department of Revenue’s (the “Department’s”) interpretation of a statute it administered, RCW 82.04.423, which provides a tax exemption for certain out-of-state businesses. “[F]or many years,” the Department treated Dot as exempt under the statute. *Id.* at 916. Then, in late 1999, the Department revised its interpretation of the statute and imposed additional requirements on businesses to qualify for the exemption. *Id.* at 917. The Department later assessed taxes against Dot based on its new interpretation.

Dot challenged the assessment. The trial court and Court of Appeal enforced it on the grounds that the Department’s new interpretation was reasonable. This Court reversed.

The Court rejected the Department’s new interpretation of RCW 82.04.423 because it inserted words into the statute that were not there.

*Id.* at 920 (“We cannot add words or clauses to a statute when the legislature has chosen not to include such language.”). In rejecting the Department’s revised interpretation, the Court declined to afford any deference to it:

Before the 1999 revision to WAC 458-20-246, the Department interpreted the statute to permit an out-of-state seller, like Dot, to claim 100 percent exempt status from the B&O tax even though some of its sales consisted of nonconsumer products. This had been the case for companies in a similar situation to Dot apparently since 1984, just after the statute was enacted. *The wording of the statute has not changed since its enactment; only the Department’s interpretation and application of the statute have changed. Considering the foregoing, we reject the Department’s interpretation.* To do otherwise would add words to and rewrite an unambiguous statute.

The Department argues that its statutory interpretation is entitled to judicial deference. While we give great deference to how an agency interprets an ambiguous statute within its area of special expertise, “such deference is not afforded when the statute in question is unambiguous.” [citation] *The Department’s argument for deference is a difficult one to accept, considering the Department’s history interpreting the exemption. Initially, and shortly after the statutory enactment, the Department adopted an interpretation that is at odds with its current interpretation.* One would think that the Department had some involvement or certainly awareness of the legislature’s plans to enact this type of statute. *As a general rule, where a statute has been left unchanged by the legislature for a significant period of time, the more appropriate method to change the interpretation or application of a statute is by amendment or revision of the statute, rather than a new agency interpretation.*

166 Wn2d. at 921 (emphasis added).

*Dot Foods* is squarely on point. RCW 48.22.005(7)'s "necessary" standard has remained unchanged since it was originally adopted in 1993; only the Commissioner's interpretation has changed. To the extent the Commissioner's current view conflicts with his office's historical views, it should be afforded no deference.

**V.  
THE COMMISSIONER'S CURRENT VIEW  
DOES NOT MAKE SENSE**

The Commissioner's current view should also be afforded no persuasive value because it is internally inconsistent, contravenes basic rules of interpretation, and conflicts with the regulation as a whole.

According to the Commissioner, the Court should answer "yes" to both certified questions because MMI *both conflicts and comports with the "necessary" standard*. The Commissioner states:

One appropriate manner of defining "reasonable" and "necessary" would be to presume that all services that aid in reaching maximum medical improvement are necessary. But a contract cannot, consistent with WAC 284-30-395(1) and RCW 48.22.005(7), define "necessary" as limited to treatment that leads to maximum medical improvement.

(Commissioner's Brief, p. 11). The Commissioner offers no authority in support of this view, which creates more confusion than clarity. The Commissioner appears to be saying that MMI is a "one-way street," where an insurer can consider it in support of paying PIP benefits but not to limit

PIP benefits. But the Commissioner cannot explain when an insurer could limit benefits as not “necessary,” or whether “necessary” provides any limitation at all.

Given the absence of clear guidance from the Commissioner, accepting his current view would violate the most fundamental tenet of due process: that a law give fair warning of what conduct violates it. *Stastny v. Board of Trustees*, 32 Wn.App. 239, 252-253, 647 P.2d 496, 505 (1982) (internal citation omitted) (“Any statute, including a rule or regulation of an administrative agency, which forbids an act in terms so vague persons of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law.”); *Myrick v. Bd. of Pierce County Commissioners*, 102 Wn.2d 698, 708, 677 P.2d 140, 146 (1984) (finding regulation requiring massage therapists be “fully clothed” void for vagueness “because it fails to give fair warning of what manner of dress will run afoul of the law”). Due process considerations are particularly compelling here, given the history of the Commissioner’s enforcement of the “necessary” standard. State Farm only defined “necessary” in its policy form after the Commissioner compelled it to do so and specifically approved its definition in terms of MMI. The Commissioner’s office did not express a different view of State Farm’s form until 2015, more than 20 years later.

The Commissioner also argues that, because “necessary” is undefined, and RCW 48.22.005(7) requires coverage for “all reasonable and necessary expenses,” it should be interpreted broadly. (Commissioner’s Brief, p. 13). But the Commissioner does not offer a competing definition, and as a general rule “[w]hen a term is undefined by statute, it should be given its ordinary meaning.” *Delagrave v. Employment Sec. Dep’t*, 127 Wn.App. 596, 111 P.3d 879 (citing *State ex rel. Graham v. Northshore Sch. Dist. No. 417*, 99 Wn.2d 232, 244, 662 P.2d 38 (1983)); *Manson v. Foutch-Miller*, 38 Wn.App. 898 (interpreting “accident” in OSHA regulation according to its plain meaning); *State v. Kintz*, 169 Wn.2d 537, 547, 238 P.3d 470 (2010) (looking to Webster’s dictionary to interpret the term “occasion” in a statute).

“Necessary,” in common usage, is a restrictive term, not an expansive one. It is equivalent to “essential.” (State Farm’s Brief, p. 38 and authority cited therein). Adopting a broad definition, as the Commissioner urges, would simply obviate the term. No rule of construction permits interpreting a statute by excising words from it. *Davis v. Dep’t of Licensing*, 137 Wn.2d 957, 969, 977 P.2d 554 (1999) (“[S]tatutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous.”).

The Commissioner additionally argues that “[i]nterpreting WAC 284-30-395(1) in a way that allows carriers to eliminate certain types of medical and hospital services would allow carriers to eliminate nearly all medical and hospital services by simply defining them as ‘unnecessary’” and “make PIP coverage largely illusory.” (Commissioner’s Brief, p. 11). Neither assertion is true here.

First, State Farm’s definition does not eliminate any type of covered medical service. It does not, for example, exclude coverage for experimental treatments, as many health insurance policies do. (Dkt. 39-1, p. 24; State Farm’s Brief, Exh. 3). It also does not restrict the type of provider an insured may treat with, as many health networks do. (*Id.*).

Second, defining “necessary” in terms of MMI in no way renders its PIP coverage illusory, as Plaintiff’s own case shows. State Farm paid all submitted medical expenses for Plaintiff’s soft-tissue back “sprain condition” for nearly nine months after the July 2012 accident. (Dkt. 38-2, p. 13; Dkt. 39-1, pp. 80-98; Dkt. 39-2, pp. 1-30). That included more than \$9,000 for massage treatments alone, most of which State Farm later learned were un-prescribed. (Dkt. 39-1, pp. 80-98, Dkt. 39-2, pp. 1-30). State Farm only stopped paying for massage and chiropractic treatment after Plaintiff’s own chiropractor advised that he was stable, had no further treatment scheduled and had reached MMI. (Dkt. 30, pp. 29-30). But,

that MMI finding did not terminate all PIP benefits. State Farm continued to pay for medical services Plaintiff received related to a separate shoulder injury. (Dkt. 39-1, p. 67-68). In all, State Farm paid \$20,916 in PIP benefits on Plaintiff's claim. (Dkt. 39-2, pp. 31-32).

The finding urged by the Commissioner on the first question – that an insurer violates WAC 284-30-395(1) if it terminates PIP benefits based on a finding that services were not essential to achieving MMI – also ignores the plain terms of WAC 284-30-395(1), which has no application to a decision to terminate PIP benefits. Consistent with its intended purpose as a disclosure regulation, the only thing WAC 284-30-395(1) requires an insurer to do is to send a letter explaining PIP benefits “within a reasonable time after receipt of actual notice of an insured’s intent to file” a PIP claim and before denying, limiting or terminating PIP benefits. WAC 284-30-395(1). Thus, the only way an insurer can violate WAC 284-30-395(1) is by not sending the benefits disclosure letter. Everyone agrees that State Farm sent that letter here. (Dkt. 30, p. 24).

The next subsection of the regulation – WAC 284-30-395(2) – applies when an insurer decides to terminate PIP benefits. It requires an insurer to explain the basis for its decision, and specifies that “a simple statement ... that the services are ‘not reasonable or necessary’ is insufficient.” WAC 284-30-395(2). In other words, an insurer *violates*

Subsection (2) if it states only that further treatment is not “necessary.” Thus, Subsection (2) compels insurers to explain any determination that medical expenses were not “necessary,” but provides no direction regarding the factors an insurer should consider in making that determination. WAC 284-30-395(2).

The Commissioner does not mention Subsection (2). But consistent with Subsection (2)’s requirement that an insurer explain any not “necessary” determination, and the absence of any “necessary” definition in either the statute or the regulation, the Commissioner does urge the Court to answer the second certified question “yes” - that MMI *can be consistent with* “necessary” as used in the regulation. (Commissioner’s Brief, p. 9).

In sum, the Commissioner recognizes that neither RCW 48.22.005(7) nor WAC 284-30-395 define “necessary,” that “necessary” can be defined in many different ways, and that MMI can be consistent with “necessary.” (Commissioner’s Brief, p. 9). If the Commissioner believes that a specialized definition of “necessary” is required in the PIP context, or that State Farm’s policy form definition of “necessary” should change, then the Commissioner should promulgate a new rule or withdraw approval of State Farm’s policy form (which will then allow State Farm to pursue its administrative remedies). Either of those agency actions would

provide due process protections, including adequate notice, to all interested parties. To date, no such action has been taken.

**VI.**  
**CONCLUSION**

Based on the foregoing, and the arguments made in State Farm's other briefing, State Farm respectfully requests that the Court afford the Commissioner's current interpretation of "necessary" in RCW 48.22.005(7) and WAC 284-30-395(1) no deferential or persuasive value, and decide the certified questions in favor of State Farm.

DATED this 26th day of February, 2018

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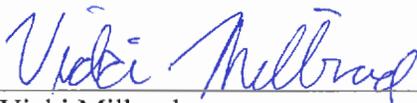
CERTIFICATE OF SERVICE

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**Comments:**

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