

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'S RESPONSE BRIEF**

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## I. INTRODUCTION

State Farm's Personal Injury Protection ("PIP") coverage in Washington defines "necessary" medical expenses to include treatment "essential to achieving maximum medical improvement" (or "MMI"). The District Court has asked this Court to decide whether State Farm's definition – which the Washington Office of the Insurance Commissioner ("OIC") has repeatedly approved – comports with WAC 284-30-395. The certified record and Washington law plainly show that it does.

That record begins with State Farm's 1992 auto policy form filing with the OIC. State Farm sought approval of a form that provided PIP coverage for an insured's "necessary" medical expenses, but did not define "necessary" or mention MMI. The OIC rejected that form because it did not define "necessary," and directed State Farm to provide a definition. Rather than formulate its own definition, State Farm proposed deferring to the Legislature which, at the time, was debating House Bill 1233. That legislation required auto insurers to offer certain PIP coverages, including up to \$35,000 in "medical and hospital benefits." The Bill's definitions section (later codified as RCW 48.22.005) defined "medical and hospital benefits" to include "reasonable and necessary expenses," but did not define the terms "reasonable" or "necessary."

The OIC refused State Farm's proposal, and insisted that State Farm define "necessary" in its policy form. State Farm complied. It proposed defining "necessary" in terms of MMI, a term already used in other no-fault contexts in Washington. The OIC *approved* State Farm's definition effective July 1, 1994 – the same day RCW 48.22.005 became effective.

Three years later, the OIC adopted WAC 284-30-395, which incorporated RCW 48.22.005's definition of "medical and hospital benefits." WAC 284-30-395 is a disclosure regulation. It requires PIP insurers to notify insureds at the outset of a claim that PIP benefits do not apply to treatment that is not "necessary." It also explicitly prohibits insurers from terminating PIP benefits by simply stating that treatment is not "necessary." Instead, a PIP insurer must explain *why* it found the insured's treatment not "necessary." Like RCW 48.22.005 before it, WAC 284-30-395 does not define the term "necessary" or restrict what factors an insurer may consider in making a "necessary" determination.

In 2006, nine years after promulgating WAC 284-30-395, the OIC again approved State Farm's MMI language in its current form. That MMI language appeared in Plaintiff's auto policy when he was involved in a July 2012 accident. Following the accident, Plaintiff treated with a chiropractor and massage therapist for a back "sprain condition" for more

than eight months. State Farm paid for that treatment under Plaintiff's PIP coverage until April 2013, when Plaintiff's chiropractor reported that he had no further treatment scheduled, was stable, and had reached MMI.

Plaintiff disputed State Farm's decision, filed this lawsuit, and contacted the OIC. That set in motion yet another review of State Farm's MMI language, which culminated in a September 2016 opinion by the OIC's Legal Department. That opinion found State Farm's MMI language "*consistent* with the 'not necessary' denial basis in WAC 284-30-395(1)(b)." (Dkt. 74-1)(emphasis added).

Thus, in the two decades since the Washington Legislature adopted the "necessary" standard for PIP "medical and hospital benefits," the OIC has approved of State Farm defining "necessary" in terms of MMI *at least three times*. Washington law affords those findings great weight in these proceedings, but Plaintiff virtually ignores them. Instead, he raises a host of other arguments in an effort to convince this Court to find a regulatory violation where the regulator found none. Those attempts fail.

Plaintiff first tries to characterize MMI as a separate requirement of coverage, rather than a component of State Farm's "necessary" definition. As support, he relies on a State Farm form letter that provides only a summary of PIP coverage to insureds, and disclaims that it has any impact on the policy's express terms, which control. Even if

Washington’s context rule allowed Plaintiff to rely on extrinsic evidence to contradict the policy terms, which it does not, that form letter does not support his claim.

Plaintiff next argues that State Farm’s MMI language conflicts with the word “necessary” in WAC 284-30-395(1)(b). That claim ignores the policy form itself, which defines “necessary” *in terms of* MMI. It also ignores Subsection (2) of WAC 284-30-395, which bars insurers from terminating PIP benefits by simply stating that treatment is not “necessary.” State Farm’s MMI language provides the clarification of “necessary” required by Subsection (2).

Plaintiff also contends that MMI cannot be consistent with any reasonable interpretation of “necessary,” while disregarding that Washington law has long employed MMI or equivalent factors in other no-fault contexts, including workers’ compensation. Indeed, the OIC, the Department of Labor & Industries and this Court have all found MMI consistent with “necessary” medical expenses in the no-fault context.

Plaintiff then offers his own definition of “necessary” – purportedly drawn from tort law principles – which makes no logical or legal sense. His definition actually incorporates the undefined term “necessary” rather than defining it. It also incorporates the separate “related to the accident” prong enumerated in WAC 284-30-395(1)(c),

thereby rendering that subsection superfluous. Even worse, under Plaintiff's definition, "necessary" medical services are whatever the treating provider says they are, without any right to question the treater's judgment. That novel formulation of the term "necessary" is inconsistent with (a) Washington tort law generally, (b) the OIC's understanding of "necessary" in the PIP context, and (c) other provisions of WAC 284-30-395, which apply precisely when an insurer relies on the opinion of *non-treating* medical providers in making a "necessary" determination.

Plaintiff's heavy reliance on policy arguments and the PIP law of other states is also misplaced. There is no basis to assume, as Plaintiff argues, that the Legislature or OIC intended to adopt a tort definition of "necessary" here. Nor is there any reason to assume that considering MMI in PIP benefits determinations will deprive a severely injured claimant life-saving medical care, or even palliative care. In practice, MMI only comes into play where, as here, a claimant experiences relatively minor injuries and treats for far longer than expected.

Finally, Plaintiff's out-of-state authority turns on the specific PIP laws of those states and consists largely of outdated case law from New Jersey. That state recently reformed its law to reign-in overtreating PIP claimants and adopted a far stricter "medically necessary" standard than MMI. New Jersey provides a prime example of the wisdom of deferring

to the expertise of the state regulator in developing a specialized “necessary” definition in the highly-regulated PIP context.

In sum, State Farm’s policy definition of “necessary” in terms of MMI is consistent with both WAC 284-30-395 and Washington no-fault law generally. The Court should, therefore, answer the certified questions in State Farm’s favor.

## II. CERTIFIED QUESTIONS

1. Does an insurer violate WAC 284-30-395(1)(a) or (b) if it denies, limits or terminates an insured’s medical or hospital benefits claim based on a finding of MMI?

No, because WAC 284-30-395(1)(b) states that benefits may be denied, limited or terminated when treatment is not “necessary” and State Farm’s approved auto policy form defines “necessary” in terms of MMI. The OIC compelled State Farm to include that definition in its policy form after the Washington Legislature adopted the “necessary” standard for PIP medical expenses, and has repeatedly approved it.

2. Is the term “maximum medical improvement” consistent with the definition of “reasonable” or “necessary” as those terms appear in WAC 284-30-395(1)?

Yes, because (a) the same regulator that promulgated WAC 284-30-395 approved of State Farm defining “necessary” in the PIP context in terms of MMI, (b) another Washington regulator and this Court recognize that MMI is consistent with “necessary” in the no-fault context, and (c) Plaintiff’s competing “necessary” definition lacks legal or logical support.

### III. STATEMENT OF THE CASE

#### A. The OIC Compels State Farm to Define “Necessary”, and Approves its Definition in Terms of MMI

The MMI policy language at issue was first used by State Farm in 1994, following a 1992 form filing with the OIC.

On October 19, 1992, State Farm submitted to the OIC its personal auto policy form revisions which, among other things, sought to add the following underlined language to its “Medical Payments” and “First Party Benefits” coverage:

We will pay reasonable medical expenses incurred, for **bodily injury** caused by accident, for services furnished within three years of the date of the accident. These expenses are for necessary medical, surgical, X-ray, dental, ambulance, hospital, professional nursing and funeral services, eyeglasses, hearing aids and prosthetic devices.

...

We have the right to make or obtain a utilization review of the medical expenses and services to determine if they are reasonable and necessary for the bodily injury sustained.

(Dkt. 7-7, pp. 6-7, 9-10).

On December 2, 1992, the OIC disapproved the policy form filing and posed various questions to State Farm, including “how do you define ‘reasonable and necessary.’” (Dkt. 7-7, pp. 15-16). State Farm responded in a March 15, 1993 letter:

For years this coverage has stated that it will pay for reasonable and necessary expenses. In order to determine which expenses are payable under this coverage, it has always been necessary to make a determination whether incurred expenses were both reasonable and necessary. If an expense is not reasonable and necessary, it has never been payable under this coverage.

(Dkt. 7-7, p. 19).

State Farm’s answer did not satisfy the OIC. In response, the OIC again asked State Farm to define “reasonable and necessary.” (Dkt. 7-7, p. 23). On August 17, 1993, State Farm responded:

House Bill 1233<sup>1</sup> has introduced the terms “reasonable and necessary”. Their meaning will be as expressed in the statute, as eventually interpreted by the courts.

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<sup>1</sup> House Bill 1233 added new sections to the RCW requiring automobile insurers in Washington to offer PIP coverage, including at least \$10,000 and up to \$35,000 in coverage for “medical and hospital benefits,” defined as “payments for all *reasonable and necessary* expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident ....” RCW 48.22.005(7) (emphasis added). The Legislature approved HB 1233 in April 1993. 1993 Wa. ALS 242, 1999 Wa. HB 1233. Its amendments to the RCW became law on July 1, 1993, but certain sections (including RCW 48.22.005) did not become effective until July 1, 1994. *Id.* During that time, the OIC had authority to adopt rules required to implement RCW 48.22.005 and its “necessary” standard. *Id.*; RCW 48.22.105.

(Dkt. 7-7, p. 26).

The OIC rejected that proposal too, and again demanded that State Farm define “reasonable and necessary” in its policy form. (Dkt. 7-7, p. 40). In its October 13, 1993 response, the OIC noted its concern that “people will not understand what ‘reasonable and necessary’ medical expenses are unless those terms are clearly defined and explained.” (*Id.*) The OIC continued:

**We will reconsider your forms *only if* you define the phrase “reasonable and necessary.” This definition must clearly state when benefits will be denied in language the average layperson can understand. Until we receive an amendment that conforms to this requirement, we will continue to hold your filings as disapproved ....**

(*Id.*) (emphasis added).

On January 18, 1994, State Farm submitted the following proposed definitions of “reasonable” and “necessary”:

Expenses are reasonable only if they are consistent with the usual fees charged by the majority of similar medical providers in the geographical area in which the expenses were incurred for the specific medical service.

Services are necessary only if the services are rendered by a licensed medical provider within the scope of the provider’s practice and license and are essential in achieving maximum medical improvement for the ***bodily injury*** sustained in the accident.

(Dkt. 7-7, p. 41) (underline added).

By letter dated February 14, 1994, the OIC ***approved*** State Farm’s MMI language. (Dkt. 7-7, p. 46). That language became effective in State

Farm's PIP coverage on July 1, 1994 – the same day RCW 48.22.005(7)'s "necessary" standard became effective. (Dkt. 7-8 p. 11).

**B. The OIC Promulgates WAC 284-30-395, Which Requires Insurers to Explain the Basis of Any Not "Necessary" Determination, But Does Not Define "Necessary"**

Three years later, the OIC promulgated WAC 284-30-395. The regulation mandated that auto insurers provide certain disclosures to insureds regarding PIP coverage and benefits determinations, and incorporated the same "reasonable" and "necessary" language included in RCW 48.22.005(7). Its introductory statement provides, in part:

The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without *adequate disclosure to insureds* of their bases for such actions. *Personal injury protection benefits are a significant element in the cost of automobile liability insurance and limiting the increases in such costs is lawful* under 48.22 RCW. ... The following standards *apply to medical and hospital benefits* relating to automobile personal injury protection benefits in an automobile liability insurance policy, *as those terms are defined in RCW 48.22.005(1), (7), and (8)*, and as prescribed at RCW 48.22.085 through 48.22.100. This section *applies only where the insurer relies on the medical opinion of health care professionals to deny, limit or terminate medical and hospital benefits claims.* ...

WAC 284-30-395 (emphasis added).<sup>2</sup>

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<sup>2</sup> As set forth above, RCW 48.22.005(7) defines "medical and hospital benefits" to include "reasonable and necessary expenses," but does not further define "reasonable" or "necessary." *See Fn. 1, supra.* Complete

Subsection (1) of WAC 284-30-395 requires insurers to provide a written explanation of their PIP coverage “within a reasonable time” after learning of an insured’s claim:

- (1) Within a reasonable time after receipt of actual notice of an insured’s intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to denying, limiting or terminating an insured’s medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit or terminate benefits if the insurer determines that the medical and hospital services:
  - (a) Are not reasonable;
  - (b) Are not necessary;
  - (c) Are not related to the accident; or
  - (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

WAC 284-30-395(1).

If an insurer decides to “deny, limit or terminate” PIP benefits, then Subsection (2) applies. It states:

- (2) Within a reasonable time after an insurer concludes that it intends to deny, limit or terminate an

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copies of WAC 284-30-395 and RCW 48.22.005 are attached as Exhibits 1 and 2 hereto. RAP 10.3. The State Farm auto policy page containing the “necessary” definition at issue here is attached as Exhibit 3. *Id.*

insured's medical and hospital benefits, the insurer ***shall provide an insured with a written explanation that describes the reasons for its action.*** The insurer shall include the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. ***A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.***

WAC 284-30-395(2) (emphasis added).

Thus, Subsection (2) makes clear that, while an insurer may properly decline to pay for unnecessary treatment, it cannot decline to pay for treatment by simply stating that it is not "necessary." Instead, the insurer must explain *why* it found that treatment unnecessary. Neither WAC 284-30-395 nor RCW 48.22.005(7) limits the factors an insurer may consider in making a "necessary" determination.

WAC 284-30-395 further provides that, in making a "necessary" determination, the insurer may rely upon the opinion of a non-treating medical provider (often referred to as an independent medical examiner or "IME"). When the insurer relies upon the opinion of an IME, Subsections (3) through (5) also apply.<sup>3</sup> WAC 284-30-395(3)-(5).

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<sup>3</sup> Subsection (3) identifies the qualifications such a medical provider must possess. *Id.* Subsection (4) includes file documentation requirements, and

**C. The OIC Again Approves of State Farm's Consideration of MMI as a Component of "Necessary"**

Thirteen years after the Legislature adopted RCW 48.22.005, and nine years after promulgating WAC 284-30-395, the OIC again approved State Farm's MMI language in its auto policy form. (Dkt. 7-6, p. 55; Dkt. 7-8, p. 58; Dkt. 39-1, p. 24; Exh. 3).

The OIC's 2006 approval was far from a "rubber stamp." In fact, the OIC originally disapproved State Farm's 2006 policy form filing for several reasons, including concerns with other provisions in State Farm's PIP coverage unrelated to MMI. (Exh. 4).<sup>4</sup> After State Farm addressed those issues, the OIC approved State Farm's current Form No. 9847A.

**D. Plaintiff's Claim and Complaint**

Plaintiff was involved in an automobile accident on July 21, 2012. On August 10, 2012, State Farm sent Plaintiff a letter summarizing his PIP benefits pursuant to WAC 284-30-395(1). It began with a disclaimer making clear that the terms of the policy, not the letter, controlled the scope of coverage. (Dkt. 30, p. 24). The letter went on to explain that PIP

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Subsection (5) applies where an insured refuses to comply with a request for an IME. *Id.*

<sup>4</sup> Exhibit 4 includes official records the OIC produced to the parties on June 15, 2017, after substantive briefing ended in the District Court. This court may properly take judicial notice of them pursuant to ER 201.

coverage does not exist for services that are not reasonable, necessary or related to the accident, and specifically stated that services not essential to achieving MMI are not covered. (*Id.*).

Plaintiff treated with various medical providers after the accident. His primary treating physician was a chiropractor named Dr. Harold Rasmussen. Three months after the accident, on October 18, 2012, State Farm sent Dr. Rasmussen a questionnaire regarding Plaintiff's treatment and status. (Dkt. 30, p. 27). Dr. Rasmussen advised that Plaintiff was still under his care, had not reached MMI, and required additional treatment for his injuries. (Dkt. 30, p. 27). He expected that Plaintiff would reach MMI in February 2013. (Dkt. 30, p. 27).

Plaintiff continued treating with Dr. Rasmussen past that date. On April 2, 2013, State Farm sent Dr. Rasmussen another questionnaire and copied Plaintiff's attorney. (Dkt. 30, p. 29). In response to State Farm's newest inquiry, Dr. Rasmussen advised that Plaintiff was no longer under his care, had no further treatment scheduled, was "stable," and had reached MMI in March 2013. *Id.* That made sense, because Dr. Rasmussen had treated only a soft-tissue back "sprain condition," and the accident had occurred about nine months earlier.

Plaintiff, however, elected to continue treating without Dr. Rasmussen's knowledge and without a prescription with his massage

therapist, Jennifer McClinton. (Dkt. 34, p. 27; Dkt. 38-2, p. 7). In just the first two weeks of April, Plaintiff received four unprescribed massages from Ms. McClinton billed at \$230 each. (*Id.*; Dkt. 30, pp. 32-35). State Farm considered those bills and declined to pay them based on Dr. Rasmussen's report. In support of those payment decisions, and in compliance with WAC 284-30-395(2), State Farm sent Plaintiff Explanation of Review ("EOR") forms that included Reason Code SF546, which provided: "Services are not covered, as your provider advised us that you previously reached maximum medical improvement. Please see our prior correspondence."<sup>5</sup> (Dkt. 30, pp. 32-35).

After receiving the EOR forms in early May 2013, Plaintiff's attorney contested State Farm's payment decision and asked Dr. Rasmussen for assistance. (Dkt. 32-18, pp. 6-7). In response, Dr. Rasmussen wrote a letter summarizing Plaintiff's condition, and reiterating that Plaintiff had reached MMI in March 2013. (*Id.*) State Farm therefore maintained its payment decision.

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<sup>5</sup> Discovery in this case has revealed additional grounds for non-payment, independent of MMI. For example, the bills include charges for services Ms. McClinton did *not provide*. Ms. McClinton billed for 90 minutes of service per session, but admitted that she only provided and intended to bill for 60 minutes of service per session. (Dkt. 34, p. 27; Dkt. 38-2, p. 37). The charges were also *three times* the rate Ms. McClinton charged

However, State Farm did not stop paying PIP or any other benefits owed under its auto policy for Plaintiff's claim. It continued paying PIP benefits for treatment Plaintiff received related to a separate shoulder injury. (Dkt. 39-1, pp. 67-68). In addition, after Plaintiff settled with the other driver for his \$50,000 liability limits in March 2014, State Farm paid Plaintiff \$5,000 plus *Winters* fees of \$6,972 under his Underinsured Motorist ("UIM") coverage. (*Id.*, pp. 70-76).

Unsatisfied with those recoveries, Plaintiff filed this lawsuit in April 2014, alleging that State Farm's decision to not pay for chiropractic and massage treatment after he had reached MMI violated WAC 284-30-395. Plaintiff alleged claims for breach of contract, bad faith, and violation of the CPA and IFCA, on behalf of himself and a class of several thousand Washington consumers.<sup>6</sup>

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cash-paying patients, and \$90 more than the rate she currently charges. (*Id.*).

<sup>6</sup> While not relevant to the certified questions presented here, State Farm notes that Plaintiff's brief misstates the class definition. (Dkt. 82; Exh. 5). The certified class is now limited to claims involving non-payment of PIP medical expenses based on Reason Codes 546 and 537 (the two Reason Codes most likely, but not necessarily, to involve an MMI determination). (*Id.*) State Farm also disputes Plaintiff's claim that it "frequently" and "systematically" adjusts claims to the MMI standard. Of the more than 75,000 PIP claims made from April 2008 to October 2015, only about 3,200 – or less than 5% – involved those Reason Codes. (Dkt. 35, p. 2; Dkt. 31, pp. 2-4).

**E. Plaintiff Complains to the OIC, Which Again Affirms the Propriety of State Farm's MMI Language**

Shortly after filing this lawsuit, Plaintiff's counsel contacted an employee of the OIC's Forms Department, notified him of this lawsuit, and asked the OIC to find that State Farm's MMI language violated WAC 284-30-395.<sup>7</sup> (Dkt. 71, p. 2). The OIC Forms Department employee preliminarily agreed with Plaintiff's counsel and referred the matter to the OIC's Market Conduct Department to institute a Market Conduct Continuum Action ("Continuum Action") regarding the MMI issue. The OIC opened a Continuum Action in August 2015. (Dkt. 61, p. 2).

Meanwhile, the OIC referred the matter to its Legal Department. On September 29, 2016, the OIC's Legal Department issued a memorandum concluding that State Farm's MMI language did *not* violate WAC 284-30-395. Specifically, it found:

that the State Farm contract language does *not* violate the WAC provision and that the State Farm contract language *is consistent with* the "not necessary" denial basis in WAC 284-30-395(1)(b).

(Dkt. 74-1, p. 2-3) (emphasis added).

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<sup>7</sup> That employee was the same forms manager that authored the American Family letter that Plaintiff has relied on in this case (which Plaintiff falsely claims was authored by "the insurance commissioner"). (Brief, p. 30; Dkt. 32-2, pp. 2-3).

The Forms Department took issue with that conclusion and asked the Legal Department to reconsider it on October 7, 2016. (Dkt. 74-1, p. 5). To date, however, the OIC's Legal Department has not changed its position. Nor has the OIC's Forms Department withdrawn approval of State Farm's policy form or taken any other regulatory action against State Farm regarding its MMI language. Instead, on October 28, 2016, the OIC's Market Conduct Department advised State Farm that it had decided to close the Continuum Action without further action. (Dkt. 61, p. 2).

#### IV. STANDARD OF REVIEW

State Farm agrees that this Court reviews certified questions de novo in light of the record certified by the District Court. *Frias v. Asset Foreclosure Servs., Inc.*, 181 Wn.2d 412, 420, 334 P.3d 529 (2014). "In answering federal certified questions, we do not seek to make broad statements outside of the narrow questions and record before us." *Brady v. Autozone Stores, Inc.*, 188 Wn.2d 576, 582 fn. 8, 397 P.3d 120 (2017) (internal quotation omitted).

In deciding matters of statutory construction in particular, this Court must state "what the law is, not what it should be." *Frias*, 181 Wn.2d at 421. "The legislature, not this court, is in the best position to assess policy considerations." *Id.* (quoting *Bain v. Metro Mrtg. Grp, Inc.*,

175 Wn.2d 83, 109, 285 P.3d 34 (2012)). Thus, the Court may disregard irrelevant policy arguments and authority. *Frias*, 181 Wn.2d at 421.

Where an agency regulation is involved, the Court generally “gives a ‘high level of deference to an agency’s interpretation of its regulations’ based on the agency’s expertise and insight gained from administering the regulation.” *Brady*, 188 Wn.2d at 580 (*quoting Silverstreak, Inc. v. Dep’t of Labor & Indus.*, 159 Wn.2d 868, 885, 154 P.3d 891 (2007)).

**V.  
ARGUMENT**

**A. State Farm Does Not Violate WAC 284-30-395 by Applying its Approved “Necessary” Definition, Which Includes Consideration of MMI**

The central issue presented in this case is whether State Farm violated WAC 284-30-395 by considering MMI in determining whether treatment is “necessary”. The certified record, along with the full text of WAC 284-30-395, plainly shows that the answer to that question is “no.”

**1. The Policy Form and its History Show that MMI is a Component of “Necessary”**

An insurance agreement is a contract, and must be interpreted according to “the general rules applicable to all other contracts.” *Farmers Ins. Co. of Wash. v. Miller*, 87 Wn.2d 70, 73, 549 P.2d 9 (1976). Under those rules, “the court cannot rule out of the contract language which the parties thereto have put into it, nor can the court revise the contract under the theory of construing it, nor can the court create a contract for the

parties which they did not make themselves, nor can the court impose obligations which never before existed.” *Id.* (internal citation omitted).

Here, the clear and unambiguous provisions of State Farm’s policy show that MMI is a component of the definition of “necessary,” and not a separate, stand-alone requirement as Plaintiff claims. (Dkt. 39-1, p. 24, Exh. 3). Plaintiff misquotes State Farm’s policy in his brief by omitting part of the “necessary” definition and changing its margins. (*Compare Id. with* Brief, p. 30). In the actual form, the margins plainly show that MMI appears as a subpart of “necessary.” (Dkt. 39-1, p. 24; Exh. 3). It provides, in relevant part:

***Reasonable Medical Expenses*** mean expenses:

1. that are the lowest one of the following charges ...
2. incurred for necessary:
  - a. medical, surgical, X-ray, dental, ambulance, hospital, and professional nursing services, and
  - b. pharmaceuticals, eyeglasses, hearing aids and prosthetic devices

that are rendered by or prescribed by a licensed medical provider within the legally authorized scope of the provider’s practice and are essential in achieving maximum medical improvement for the *bodily injury* sustained in the accident.

(*Id.*)(underline added).

The certified record further underscores that MMI appears in State Farm’s policy as a component of “necessary.” It includes State Farm’s

extensive communications with the OIC, which show that State Farm's original form provided coverage for "necessary" medical expenses without defining "necessary" or mentioning MMI. (Dkt. 7-7, p. 15 to Dkt. 7-8, p. 11). Not satisfied, the OIC required State Farm to define "necessary" by refusing to approve its policy form until State Farm provided a definition. *Id.* Ultimately, the OIC approved of State Farm's "necessary" definition in terms of MMI three separate times. (*Id.*; Dkt. 74-1, pp. 2-3).

The OIC's initial approval of State Farm's MMI language came seven months after RCW 48.22.005 (which was part of House Bill 1233) became law. That statute defined "medical and hospital benefits" that all PIP insurers must offer to include "necessary" medical expenses. RCW 48.22.005(7). When the OIC later promulgated WAC 284-30-395, it echoed and incorporated that standard.<sup>8</sup> WAC 284-30-395 (Intro. & 1). Because the OIC adhered to the same "necessary" standard codified in RCW 48.22.005(7), the OIC's initial finding that MMI comports with the

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<sup>8</sup> This is consistent with the principle that "[a]n agency 'does not have the power to promulgate rules which amend or change legislative enactments ....'" *Marcum v. Dept. of Social and Health Servs.*, 172 Wn.App. 546, 559, 290 P.3d 1045 (2012) (internal citation omitted).

statutory “necessary” standard applies equally to WAC 284-30-395.<sup>9</sup> *Credit General Ins. Co. v. Zewdu*, 82 Wn.App.620, 625, 919 P.2d 93 (1996) (the OIC “has initial authority to authorize the sale of insurance policies, including the obligation to determine whether policy provisions are consistent with Washington’s insurance laws”); RCW 48.18.110 (the OIC shall withdraw any previous approval of a form if it does not comply with any regulation of the Commissioner). That initial interpretation is entitled to great weight in this proceeding. *Brady*, 188 Wn.2d at 580.

Because the plain language of State Farm’s policy form defines “necessary” in terms of MMI, and the regulator that promulgated WAC 284-30-395 has repeatedly approved of that MMI language, State Farm’s application of that MMI language in making PIP payment decisions cannot violate WAC 284-30-395(1).

## **2. Plaintiff Improperly Relies on Extrinsic Evidence to Contradict the Policy Terms**

Plaintiff ignores the OIC’s approval of State Farm’s MMI language in his brief. Instead, he argues that MMI is an “additional criteria” separate and apart from “necessary,” by relying exclusively on a

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<sup>9</sup> Plaintiff does not, and cannot, dispute that the OIC was considering the requirements of RCW 48.22.005 when it approved State Farm’s MMI language, because the OIC’s letter confirming the approval specifically referenced the statute. (Dkt. 7-8, p. 11).

form letter he received in 2012 after making his PIP claim. (Brief, pp. 13-15). Plaintiff's reliance on that letter is misplaced.

That letter, which Plaintiff calls a "Coverage Letter," does not purport to quote his policy form or control his PIP coverage. Instead, it expressly states that it is only a summary of the PIP coverage provided and that the terms of the actual policy form control:

The following is a summary of benefits available under the PIP coverage of the policy. ***All benefits are subject to the terms and conditions of the car policy applicable to this loss.*** If you do not have a copy of the car policy, please let me know and I will send one to you.

(Dkt. 30, p. 24)(emphasis added). No insured reading that letter would expect that it changes the terms of his or her PIP coverage, because the letter expressly disclaims that it has any impact on those terms. (*Id.*)

Plaintiff nonetheless relies on that letter to contradict the express terms of his policy, which Washington law does not allow. "[E]xtrinsic evidence cannot be used to delete or contradict the written terms of an agreement." *Schweitzer v. Schweitzer*, 132 Wn.2d 318, 326, 937 P.2d 1062 (1997); *International Marine Underwriters v. ABCD Marine, LLC*, 179 Wn.2d 274, 288, 313 P.3d 395 (2013) (a court "is not at liberty to revise a contract under the theory of construing it"). Washington's "'context rule' authorizes the use of extrinsic evidence only to elucidate the meaning of the words of a contract, and 'not for the purpose of

showing intention independent of the instrument.” *Schweitzer*, 132 Wn.2d at 327. The “context rule” further limits extrinsic evidence to that concerning “the circumstances under which a written instrument was executed” – in other words, evidence of contract negotiations. *Berg v. Hudesman*, 115 Wn.2d 657, 669, 801 P.2d 222 (1990).

The form letter was sent to Plaintiff long after he obtained his auto policy, and therefore cannot shed light on any “negotiations” for the policy. *See Lynott v. Nat’l Union Fire Ins. Co. of Pitts., PA*, 123 Wn.2d 678, 684, 871 P.2d 146 (1994) (recognizing that the “context rule” generally does not apply to standard form insurance contract provisions). Nor does the letter elucidate the meaning of the term “necessary” in the policy, since the letter itself says only the policy’s standard form language controls.

The only extrinsic evidence relevant to understanding the policy form here is State Farm’s correspondence with the OIC. Those communications, along with the express terms of the policy, show that the MMI language is part of the definition of “necessary.”<sup>10</sup>

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<sup>10</sup> State Farm offers those communications as evidence of the OIC’s interpretation of “necessary” in WAC 284-30-395 and RCW 48.22.005, not as extrinsic evidence relevant to interpreting its policy form under the “context rule.”

**3. Applying State Farm's MMI Language Does Not Render WAC 284-30-395(1) Meaningless – It Provides the Clarification Required by WAC 284-30-395(2), Which Plaintiff Ignores**

Plaintiff argues that applying State Farm's MMI language would render part of Subsection (1) of WAC 284-30-395 meaningless, because that regulation states the only grounds for terminating PIP benefits and does not mention MMI. That argument fails for at least two reasons.

First, it incorrectly assumes that MMI is a standard separate and apart from "necessary." As explained above, MMI is part of State Farm's definition of "necessary."

Second, it ignores Subsection (2) of WAC 284-30-395. As Plaintiff's own authority supports, this Court cannot interpret Subsection (1) in a vacuum. It must instead interpret Subsections (1) and (2) together, "so that all the language used is given effect, with no portion rendered meaningless or superfluous." *Davis v. Dept't of Licensing*, 137 Wn.2d 957, 969, 977 P.2d 554 (1999) (internal citation and quotation omitted).

Unlike Subsection (1), which applies at the outset of a claim (and before any payment decision is made), Subsection (2) applies to payment decisions. It prohibits an insurer from denying, terminating or limiting PIP benefits by simply stating that the treatment is not "necessary." WAC 284-30-395(2). Instead, it requires an insurer to explain the basis of

payment decisions *beyond* simply reciting the “necessary” standard. Subsection (2) does not, however, restrict what factors an insurer may consider in making a not “necessary” determination.

Plaintiff completely ignores Subsection (2). Even worse, Plaintiff’s reading of Subsection (1) conflicts with Subsection (2). According to Plaintiff, Subsection (1) requires an insurer to deny PIP medical expense claims only by reciting one of the enumerated terms, including the term “necessary.” But that flies in the face of Subsection (2), which mandates that an insurer provide a further explanation as to why a particular medical expense was not “necessary.” Because Plaintiff’s reading of Subsection (1) would render Subsection (2) meaningless, it must be rejected. *Davis*, 137 Wn.2d at 969.

**4. Plaintiff Cites No Law or Policy Justifying His Attempt to Override the Express Policy Terms**

Plaintiff also argues, indirectly, that the public policy behind PIP coverage overrides the express policy terms. That claim fails.

“[A]s a private contractor, the insurer may place limitations on certain policy provisions without violating a statute or public policy.” *Smith v. Continental Cas. Co.*, 128 Wn.2d 73, 83, 904 P.2d 749 (1995) (enforcing “who is an insured” provision where UIM statute did not mandate any particular definition). This Court “only rarely invoke[s]

public policy to override express terms of insurance policies.” *New Hampshire Indem. Co., Inc. v. Budget Rent-A-Car Systems, Inc.*, 148 Wn.2d 929, 935, 64 P.3d 1239 (2003). “Absent prior expression of public policy from either the Legislature or prior court decisions,” the Court’s inquiry as to whether a policy provision “clearly offends the public good must be answered in the negative.”<sup>11</sup> *General Ins. Co. v. Emerson*, 102 Wn.2d 477, 483, 687 P.2d 1139 (1984).

This Court has never invoked public policy to invalidate “any affirmative grant of coverage made by an insurer.” *Fluke Corp. v. Hartford Accident & Indem. Corp.*, 145 Wn.2d 137, 144, 34 P.3d 809 (2001). Public policy has only been invoked to “nullify[] policy *exclusions* in two areas: one relates to underinsured motorist insurance (UIM) coverage authorized under RCW 48.22.030; the other involved the Financial Responsibility Act, RCW 46.29.” *Id.* (italics in original). This case does not involve a policy exclusion or either of those coverages – it involves PIP coverage mandated under RCW 48.22.005 et seq., which is

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<sup>11</sup> This Court also rarely invokes RCW 48.18.510 to override express policy terms. The last time this Court relied on that statute to conform a policy that conflicted with the insurance code was more than half a century ago. *Tebb v. Continental Cas. Co.*, 71 Wn.2d 710, 430 P.2d 597 (1967). In *Tebb*, unlike here, no party disputed that the policy form at issue directly conflicted with the statute.

“separate and distinct” from UIM and liability coverage.<sup>12</sup> *Safeco Ins. Co. v. Woodley*, 150 Wn.2d 765, 770, 82 P.3d 660 (2004).

Plaintiff also cites no applicable public policy that conflicts with State Farm’s “necessary” definition. Contrary to Plaintiff’s bare assertion, PIP coverage is not intended “to make an insured whole” by compensating an insured for all losses resulting from an accident. (Brief, p. 23). As this Court recognized in *Keenan v. Indus. Indem. Ins. Co.*, 108 Wn.2d 314, 738 P.2d 270 (1987), PIP provides limited no-fault coverage for certain economic damages. *Id.* at 321-322. *Ainsworth v. Progressive Cas. Ins. Co.*, 180 Wash.App. 52, 322 P.3d 6 (2014) similarly explained:

The no-fault insurance system and personal injury protection (PIP) benefits are intended to provide victims of motor vehicle accidents adequate and prompt reparation for certain economic losses at the lowest cost to both the individual and the no-fault insurance system.

*Id.* at 62 (internal citation omitted).

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<sup>12</sup> Even in the UIM context, courts will not use public policy to invalidate policy terms if those terms do not directly conflict with the language of the UIM statute or its underlying purpose. *Bohme v. Pemco Mut. Ins. Co.*, 127 Wn.2d 409, 412, 899 P.2d 787 (1995) (enforcing policy language that did not directly conflict with the UIM statute or its purpose); *Miller*, 87 Wn.2d at 75 (rejecting claim that the public policy of the UIM statute prohibited the policy’s definition of “automobile” because the statute did not define “automobile”); *Smith*, 128 Wn.2d at 83 (enforcing the policy’s definition of “who is an insured” over objection that it violated the public policy behind the UIM statute, which did not mandate any particular

The express terms of WAC 284-30-395 likewise recognize the need to balance the competing policies underlying PIP coverage: prompt and adequate compensation to accident victims and cost-containment to the overall PIP system. WAC 284-30-395 (Intro.). Consistent with that balance, Washington’s statutorily-mandated PIP coverage includes cost-containment limitations not present in other coverages or areas of law.<sup>13</sup>

Washington courts similarly reject “that PIP benefits offer the same type of guaranteed coverage generally provided by health insurance.” *Sadler v. State Farm Mu. Auto Ins. Co.*, 2008 U.S. Dist. LEXIS 71665, \*32, 2008 WL 4371661 (W.D. Wa. Sept. 22, 2008), *aff’d* 351 Fed.Appx. 234 (9th Cir. 2009) (rejecting contention that PIP insurer owed same duties as health insurer, and granting summary judgment to insurer on claim alleging wrongful failure to pre-authorize medical

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definition); *Daley v. Allstate Ins. Co.*, 135 Wn.2d 777, 958 P.2d 990 (1998), *infra*.

<sup>13</sup> For example, PIP “medical and hospital” benefits end three years after the subject accident. RCW 48.22.005(7); WAC 284-30-395. Also, automobile insurers must offer only up to \$35,000 in PIP “medical and hospital benefits,” far lower than UIM bodily injury coverage limits (which generally mirror the policy’s liability limits). RCW 48.22.100, 48.22.030(3). An insurer may also conduct an IME to evaluate the reasonableness or necessity of further treatment. WAC 284-30-395(3); *Sadler*, 2008 U.S. Dist. LEXIS 71665, \*32.

treatment under PIP coverage, as PIP insurer owed no pre-authorization duty).

Moreover, the OIC's express purpose in promulgating WAC 284-30-395 was to improve disclosures regarding an insured's PIP benefits. WAC 284-30-395 (Intro.). State Farm's MMI language furthers that purpose by clarifying the term "necessary" – a term that WAC 284-30-395 specifically recognizes requires clarification in practice – before any benefits determination is made.

**B. MMI is Consistent with "Necessary" in this Context.**

The second certified question asks whether MMI is consistent with "necessary" under WAC 284-30-395. Plaintiff argues that "the MMI standard is not equivalent to any reasonable definition of necessary." (Brief, p. 26). He ignores that the Washington OIC, Department of Labor & Industries, and even this Court have all found MMI consistent with "necessary" in no-fault contexts. Moreover, Plaintiff's competing definition of "necessary" does not make logical or legal sense.

**1. The OIC Has Repeatedly Found that MMI Comports with "Necessary" in this Context**

As recounted above, the OIC has repeatedly found the MMI language in State Farm's policy consistent with "necessary" as that term appears in RCW 48.22.005 and WAC 284-30-395. Plaintiff disregards

this fact. Instead, he argues that the “insurance commissioner” only “weighed in” on the propriety of MMI in the context of an American Family policy and found that it violated WAC 284-30-395. (Brief, p. 30). Plaintiff is wrong.

The American Family policy language Plaintiff cites did not include MMI. (Dkt. 32-2, pp. 2-3). Also unlike State Farm’s MMI language, no facts support that the OIC had ever (a) negotiated that specific language with American Family, or (b) compelled American Family to include it in its policy – either before or after RCW 48.22.005(7)’s “necessary” standard went into effect.

The OIC also did not “weigh in” on American Family’s policy language. (Brief, p. 30). A single OIC Forms Department employee found that American Family’s policy language violated WAC 284-30-395 – the same employee that Plaintiff’s counsel contacted in this case. (Dkt. 32-2, pp. 2-3; Dkt. 71, p. 2). His letter states: “I have reviewed the Personal Injury Protection contract language in the [American Family]

policy and find it in violation of WAC 284-30-395(1).”<sup>14</sup> (Dkt. 32-2, p. 2) (emphasis added). No facts support that American Family opposed that employee’s finding, or challenged it in an administrative or civil proceeding.

In addition, no facts support that the Insurance Commissioner or the OIC’s Legal Department had any involvement in, or even knowledge of, that employee’s conclusion. The facts *do* show that the OIC’s Legal Department recently *disagreed* with that employee when considering the same question before this Court, and found that State Farm’s MMI language was consistent with WAC 284-30-395. (Dkt. 74-1, pp. 2-6).

In sum, the American Family policy involved different language, and American Family did not challenge it. It has no precedential or persuasive value in this case.

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<sup>14</sup> Even assuming that employee’s finding could amount to an “agency” interpretation regarding State Farm’s MMI language, which it does not, it is not entitled to any weight here because, at best, it amounts to a changed interpretation from the OIC’s 1994 determination that MMI was consistent with “necessary” in RCW 48.22.005(7). This Court affords no deference to an agency’s changed interpretation of an unchanged statute it administers. *See Dot Foods, Inc. v. Dep’t of Revenue*, 166 Wn.2d 912, 921, 215 P.3d 185 (2009) (not affording an agency interpretation of a statute deference where it was a “revised” interpretation of an unchanged statute).

2. **Washington Workers' Compensation Laws Recognize that MMI Comports with "Necessary"**

State Farm's definition of "necessary" in terms of MMI is not unique to State Farm's policy form. Washington's workers' compensation law also provides that treatment rendered after an injured employee has reached MMI is not "necessary." WAC 296-20-01002.

Washington's Industrial Insurance Act provides that the Department of Labor & Industries will pay for "proper and necessary" medical services rendered to injured workers. RCW 51.36.010. WAC 296-20-01002 provides:

***Proper and necessary:***

- (1) The department or self-insurer pays for ***proper and necessary health care services*** that are related to the diagnosis and treatment of an accepted condition.

...

- (3) ***The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement.*** Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. ***Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."***

WAC 296-20-01002 (1), (3) (emphasis added). This Court has recognized and enforced that MMI standard in the workers' compensation context. *Tomlinson v. Puget Sound Freight Lines, Inc.*, 166 Wn.2d 105, 111-114, 206 P.3d 657 (2009) (en banc).

Thus, treatment after a patient reaches MMI is not "necessary" under Washington's workers' compensation laws, just as it is not "necessary" under State Farm's policy.<sup>15</sup>

**3. This Court Has Found MMI Consistent With "Necessary" in the Maritime No-Fault Context**

This Court has also recognized the "maximum medical cure" standard in the maritime no-fault context. *Lundborg v. Keystone Shipping Co.*, 138 Wn.2d 658, 663, 981 P.2d 854 (1999). As Plaintiff's own authority supports, the "maximum medical cure" standard is the equivalent of MMI. *Lee v. Metson Marine Servs., Inc.*, 2012 U.S. Dist. LEXIS 155957, \*, 2012 WL 5381803 (D. Haw. Oct. 31, 2012) ("A seaman injured in the service of the ship is entitled to maintenance and cure until

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<sup>15</sup> Plaintiff cites other Washington regulations outside of the no-fault context that define "necessary" without reference to MMI. (Brief, pp. 32-33 (citing WAC 182-500-0070 and WAC 182-500-0070). Those rules were promulgated in the context of Washington's Apple Health (Medicaid), which provides broad public health benefits. But PIP is not health insurance, and the issue here is not whether "necessary" can ever be defined without reference to MMI. The issue is whether MMI can be consistent with "necessary" in the PIP context. Clearly, it can.

he reached the point of maximum medical cure,' also called *maximum medical improvement* or *MMI*.”) (emphasis added).

Under the “maximum medical cure” standard, a ship owner’s obligation to pay an injured seaman’s medical bills ends when he or she has reached a point where “future treatment will merely relieve pain and suffering but not otherwise improve the seaman’s physical condition.” *Id.* That standard (like MMI here) does not bar recovery for all palliative treatment – only recovery for treatment that will not improve a seaman’s condition, and only treatment provided after the seaman has reached “maximum cure.”<sup>16</sup> *Id.*; *Mabrey v. Wizard Fisheries, Inc.*

2008 U.S. Dist. LEXIS 9985, 2008 WL 110500 (W.D. Wa. Jan. 8, 2008)

This Court has not only enforced that MMI standard in the maritime no-fault context, it has expressly recognized that a ship owner’s obligation to pay medical expenses under it amounts to an obligation to pay *necessary* medical expenses. *Lundborg*. 138 Wn.2d at 663. As the Court explained in *Lundborg*, “seamen are entitled to cure, which is the right to necessary medical services.” *Id.*

Thus, this Court, the Washington Department of Labor & Industries, and the Washington OIC have all recognized that the MMI standard is consistent with an obligation to pay “necessary” medical expenses in the no-fault context. These facts disprove Plaintiff’s bald assertion that MMI cannot equate with any definition of “necessary.”

**C. Plaintiff’s “Necessary” Definition Fails**

Plaintiff admits that Washington law does not define “necessary” in the PIP or tort context, and that the policies underlying each area of law differ. (Brief, pp. 19, 22). Plaintiff nonetheless posits that “‘necessary’ in both the PIP and tort litigation context should be defined as:

Those treatments or services that are related to the injury producing event, and deemed necessary by the injured party’s licensed medical provider, and such treatment or services are within the standard of care for such licensed providers.

(Brief, p. 23). In other words, under Plaintiff’s novel formulation, “necessary” means whatever the treating provider says it means.

As explained below, Plaintiff’s proposed definition fails for several reasons.

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<sup>16</sup> Plaintiff’s own authority rejects the proposition that purely palliative care amounts to “necessary” care, even in the health insurance context. *Group Hospitalization, Inc. v. Levin*, 305 A.2d 248 (1972) (“[W]e do not mean to imply that the insurance clause at issue covers situations where private nurses are retained merely to alleviate discomfort or to provide the

**1. Plaintiff's Definition Conflicts with Rules of Statutory Construction and WAC 284-30-395**

“A fundamental canon of construction holds a statute should not be interpreted so as to render one part inoperative.” *Davis*, 137 Wn.2d at 969. Statutes should be harmonized where possible, and terms should not be construed in isolation. *Id.* In addition, “statutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous.” *Id.* (internal citation and quotation omitted). Courts apply statutes according to their plain meaning, and will not add words that are not there. *See, e.g., State v. LG Electronics, Inc.*, 186 Wn.2d 1, 9-10, 375 P.3d 636 (2016) (en banc).

Plaintiff's definition violates these basic rules.

First, rather than actually defining “necessary,” the proposed definition incorporates that term into the phrase “deemed *necessary* by the treating provider.” (Brief, p. 23). That standard does nothing to resolve what “necessary” actually means.

Second, it renders WAC 284-30-395(1)(c) superfluous by incorporating the separate “related to” ground set forth in that subsection into the definition of “necessary” in Subsection (1)(b). It also adds words to Subsection (1)(b) that are not there.

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patient with the companionship and convenience of a special nurse.”).

Third, Plaintiff's definition disregards the plain meaning of "necessary." As this Court has often recognized, "[w]e may discern the plain meaning of nontechnical statutory terms from their dictionary definitions." *State v. Kintz*, 169 Wn.2d 537, 547, 238 P.3d 470 (2010) (looking to Webster's dictionary to interpret the undefined term "occasion") (internal citation omitted). Here, the word "necessary" generally means "absolutely needed", "inevitable", "required to be done" or "essential." Merriam Webster's Dictionary, <http://www.merriam-webster.com/dictionary/necessary>; Oxford Dictionary, [www.oxforddictionaries.com/us/definition/american\\_english/necessary](http://www.oxforddictionaries.com/us/definition/american_english/necessary). State Farm's definition is entirely consistent with that meaning. It provides that medical services are only "necessary" if they are "essential in achieving [MMI] ...." (Dkt. 39-1, p. 24; Exh. 3).

Fourth, by deferring exclusively to the treating provider's judgment, Plaintiff's definition renders Subsection (3) superfluous and nonsensical. Subsection (3) expressly recognizes that insurers may rely on *non-treating* providers (i.e., IMEs) in deciding whether to terminate, limit or deny PIP benefits on the ground that further treatment is not "necessary." It requires insurers to consult with medical providers "currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured" in

determining whether treatment is “reasonable”, “necessary” or “related to” the subject accident. WAC 284-30-395(3).

Plaintiff’s complete deference to the treating provider’s judgment also conflicts with the OIC’s understanding of the term “necessary.” In compelling State Farm to define “necessary” in its policy form, the OIC stated:

We do not believe that the average layperson will understand what is meant by a provision that says you will pay only the “reasonable and necessary” medical expenses. If my doctor told me I needed treatment for injuries sustained in an auto accident, I would believe it to be reasonable and necessary for my automobile insurance to pay for that treatment.

(Dkt. 7-7, p. 40). Thus, even before promulgating WAC 284-30-395, the OIC recognized that the term “necessary” does not necessarily equate with a treating provider’s recommendation.

## **2. Plaintiff’s Reliance on Tort Law is Misplaced**

Plaintiff’s suggestion that any medical services recommended by a “licensed treating provider...within the standard of care ” are, by definition, “necessary” also conflicts with Washington’s tort law.

In urging that interpretation, Plaintiff misrepresents a narrow rule of tort law as a general one. He argues that tort law generally bars a tortfeasor from contesting the reasonableness or necessity of a plaintiff’s treatment. (Brief, p. 20). But the only Washington authority he cites for

that proposition involved the narrow situation where a tortfeasor tried to avoid liability for medical expenses on the ground that the treating provider *exacerbated* the plaintiff's injury. (*Id.*) (citing Restatement (Second) of Torts §457 (1965), *Lindquist v. Dengel*, 92 Wn.2d 257, 262, 595 P.2d 934 (1979), *Adams v. Allstate Ins. Co.*, 58 Wn.2d 659, 364 P.2d 804 (1961), *Martin v. Cunningham*, 93 Wash. 517, 161 P. 355 (1916)). Applying a proximate cause analysis, those cases reasoned that the tortfeasor that initially caused the injury requiring treatment should properly bear liability for any aggravation that resulted during treatment. *Id.* That narrow situation is not at issue here.<sup>17</sup>

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<sup>17</sup> Plaintiff's out-of-state authority goes beyond Section 457 of the Restatement and Washington law. It begins with *Hillebrandt v. Holsum Bakeries, Inc.*, 267 So.2d 608 (La.App. 1972), which initially quoted the Restatement rule: "A tortfeasor is liable for additional suffering caused his tort victim by inappropriate treatment by the attending physician." It then added, without citing any authority: "The tortfeasor should similarly be liable to the victim for additional monetary damage caused by excessive treatment, which is also the result of the foreseeable cumulation of fault of tortfeasor and doctor." *Id.* The only case outside Louisiana to cite *Hillebrandt's* novel rule was *Whitaker v. Kruse*, 495 N.E.2d 223, 225 (Ind. App. 1986). *Sibbing v. Cave*, 92 N.E. 2d 549 (2010), cited by Plaintiff here (Brief, pp. 21-22), simply echoes *Whitaker*. Outside of Indiana, *Whitaker* has only been cited by one precedential Arkansas state court decision, which has itself been clarified to avoid the impression that Arkansas follows a rule that any and all medical care would automatically be deemed "necessary" and recoverable. See e.g., *Worman v. Allstate Indem. Co.*, 2012 U.S. Dist. LEXIS 158798, \*7-8, 2012 WL 5410933 (W.D. Ark. Nov. 6, 2012) (clarifying that Arkansas only recognizes a "limited" rule that precludes a defendant from avoiding liability "for

Contrary to Plaintiff's claim, Washington tort law generally does not obligate a trier of fact to accept a treating physician's opinion regarding the necessity of a plaintiff's treatment. *Kadmiri v. Klassen*, 103 Wn.App. 146, 10 P.3d 1076, 151 (1997) (affirming jury award of less than the incurred medical expenses, reasoning that testimony from defendant's medical experts left the jury "free to conclude that some of Mr. Kadmiri's medical expenses were unnecessary because they were not attributable to the collision or because he was exaggerating his injuries"); *Hawkins v. Marshall*, 92 Wn.App.38, 962 P.2d 834 (1998) (court improperly instructed jury that it had to award all or none of the claimed medical expenses). "Once medical bills are admitted, 'the credibility of the evidence and the amount of the damages [is] then a question of fact for the jury.'" *Hawkins*, 92 Wn.App. at 44 (citation omitted).

Civil Rule 35 codifies a defendant's general right to dispute a plaintiff's condition, including the necessity of past or future medical treatment, by permitting the defendant to seek an independent medical examination in any case involving a dispute regarding the plaintiff's condition. CR 35. A defendant may offer an IME's opinion, as well as

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injuries caused by treating physicians during the course of reasonably sought medical care for other injuries proximately caused" by the auto accident).

any other admissible evidence, to dispute a personal injury claimant's alleged condition or the reasonableness or necessity of treatment.<sup>18</sup> See e.g., *Kadmiri*, 103 Wn.App. at 146; *Lopez v. Salgado-Guardarama*, 130 Wn.App. 87, 92, 122 P.3d 733 (2005) (upholding jury's refusal to award pain and suffering damages to personal injury plaintiff where the defense IME's testimony disputed those claims); WPI 30.07.01 (Note & Com.) (recognizing a defendant's ability to offer evidence controverting the reasonableness and necessity of a plaintiff's treatment).

Plaintiff also contends that courts outside Washington have construed "necessary" to mean "proximately result[ing] from" in the tort context. (Brief, pp. 21-22). That tort law construction cannot apply here, because WAC 284-30-395 includes a separate causation factor – "related to" the accident. WAC 284-30-395(1)(c). So, the word "necessary" in

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<sup>18</sup> Plaintiff's other authority likewise rejects the proposition that all medical care rendered a plaintiff is necessarily "necessary." In *Sebroski v. United States*, 111 F.Supp.2d 681 (D. Md. 1999), for example, the court awarded certain past medical expenses, but disallowed the cost of an MRI as well as ultrasound and electrical stimulation treatment the plaintiff's chiropractor had rendered on the ground that it was "of limited (if any) value." *Id.* at 686 fn.3. *Victum v. Martin*, 367 Mass. 404, 326 N.E.2d 12 (1975), similarly recognized the potential for litigants to "run[] up unjustified medical expenses" to increase their tort recovery, and reasoned that "where there are indications that the medical services were patently inefficient, excessively repetitions, not conducive to producing desired medical results ... the necessity for medical services may be subject to more searching inquiry." 367 Mass. at 410.

WAC 284-30-395(1)(b) must mean something different than what some courts have construed it to mean in the tort context.

Plaintiff further contends, without citing any authority, that “it seems clear that the PIP regulation adopted the reasonable and necessary terms from cases involving tort litigation.” (Brief, p. 19). He ignores that the OIC drew the standards articulated in WAC 284-30-395 from the no-fault statute (RCW 48.22.005(7)). *See* WAC 284-30-395 (Intro. & 1). The OIC also approved of State Farm’s definition of “necessary” in terms of MMI – a phrase used in the no-fault context, not the tort context – after RCW 48.22.005(7) became law. Thus, if anything, the record supports that the OIC contemplated applying no-fault standards to the terms “reasonable” and “necessary,” not tort standards.

This Court rejected a similar “tort standard” argument in *Daley v. Allstate Ins. Co.*, 135 Wn.2d 777, 958 P.2d 990 (1998). *Daley* involved a claim for UIM coverage for emotional distress damages unrelated to the insured’s physical injury. The UIM statute required coverage for “bodily injury,” but did not define that term. *Id.* at 782. The insured argued that the court should interpret “bodily injury” broadly to allow recovery for emotional distress unrelated to physical injury, because he could recover damages for that harm in a tort claim. *Id.* at 784. This Court disagreed, reasoning that the issue was *not* what the insured could recover in tort, but

what the insured could recover under the insurance policy at issue. *Id.* The Court ultimately held that the policy did not provide, and Washington's UIM statute did not require, coverage for the emotional distress damages claimed. *Id.* at 794.

Finally, Plaintiff cites WPI 105.08, which is inapposite. (Brief, p. 24). That instruction applies in malpractice cases against providers, and absolves providers of tort liability when their treatment is within the standard of care. WPI 105.08. It has nothing to do with benefits payable by PIP insurers, or PIP's "necessary" standard.

### **3. Plaintiff's Policy Arguments Fail**

Plaintiff argues that public policy supports his position, but he cites no policy underlying PIP coverage that conflicts with State Farm's MMI language. As discussed above, State Farm's MMI language is entirely consistent with the policies underlying PIP coverage generally and WAC 284-30-395 specifically.

Contrary to Plaintiff's claim, the questions presented here do not implicate a "policy prohibiting a third party from interfering with medical decisions made between an injured person and their physician."<sup>19</sup> (Brief,

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<sup>19</sup> Plaintiff's authority supporting this policy argument is inapposite. *Matter of Guardianship of Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984) involved a guardian's authority to authorize potentially life-saving surgery

p. 22). There is no basis to presume that resolving the certified questions will impact treatment decisions, as Plaintiff's own claim illustrates. After State Farm stopped paying for chiropractic and massage treatment under its PIP coverage based on Dr. Rasmussen's MMI finding, Plaintiff elected to continue treating. Plaintiff received all treatment that he needed from all of his providers regardless of State Farm's PIP benefits determination. (Dkt. 38-1, pp. 124-125). He also received, in addition to PIP benefits payments, a liability payment from the other driver of \$50,000, and a UIM settlement payment. (Dkt. 39-1, pp. 70-76).

Plaintiff's assertion that the MMI standard would deny "palliative" care to a PIP insured with a traumatic brain injury is also not credible. PIP coverage limits are relatively low. By statute, an insurer need offer up to only \$35,000 in PIP coverage for "medical and hospital benefits." RCW 48.22.100. The initial hospital bill for a severely injured insured would

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for an elderly ward that had declined it. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007), involved a wrongful life claim against an obstetrician on the theory that she did not adequately inform the parents of the permanent, debilitating disabilities their child would suffer from the life-saving medical treatment provided. Plaintiff's claim centers on the necessity of massages he received without a prescription after his own provider found that he had reached MMI.

likely exhaust those limits. In practice, MMI generally comes into play only where, as here, an insured has relatively minor injuries and continues to seek treatment long after those injuries would be expected to resolve.

Plaintiff's claim that State Farm's MMI standard categorically excludes "palliative care" is also incorrect. The MMI standard does not exclude coverage for palliative care before an insured reaches MMI. (Dkt. 32-12, p. 12). Moreover, State Farm's claims specialists have the discretion to pay for care after an MMI finding. (Dkt. 39, p. 3). In Plaintiff's case, State Farm paid for about 40 massages before Plaintiff reached MMI (far more than the 12-16 massages his doctor actually prescribed), and continued to pay for treatment for Plaintiff's shoulder injury after he reached MMI. (Dkt. 34, p. 27; Dkt. 38-1, pp. 127-128; Dkt. 39-1, pp. 67-68, 80-98; Dkt. 39-2, pp. 1-27).

#### **4. Plaintiff's Out of State PIP Law Does Not Assist Him**

Plaintiff reliance on out-of-state authority interpreting "necessary" under the respective PIP law of those states also does not assist him.

For example, Plaintiff cites to a one-paragraph long decision out of New York's intermediate appellate court in 1999. *Hobby v. CNA Ins. Co.*, 267 A.D.2d 1084 (1999). He ignores a 2000 decision out of that same court which upheld an arbitrator's finding that an insurer owed no further no-fault benefits under New York law after a medical provider found that

the insured had reached MMI. *Gaul v. Comm. Union Ins. Co.*, 268 A.D.2d 816 (2000) (“This medical provider stated that chiropractic treatment, including massage therapy, was no longer necessary and that petitioner had ‘reached maximum medical improvement.’”).

Plaintiff also relies heavily on New Jersey case law from the 1980s. (Brief, pp. 25-27, 32 (citing *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 219 N.J. Super. 208, 530 A.2d 56 (1987); *Miskofsky v. Oh. Cas. Ins. Co.*, 203 N.J. Super. 400, 497 A.2d 223 (1984); *Cavagnaro v. Hanover*, 236 N.J. Super. 287, 291, 565 A.2d 728 (1989)). He ignores that, in the late 1990s, the New Jersey Legislature enacted significant PIP law reform based on evidence that PIP benefits were “being overutilized” under the former law. *Coalition for Quality Healthcare v. New Jersey Dept. of Banking & Ins.*, 348 N.J. Super. 272, 284, 791 A.2d 1085 (2002). To reign in fraud and the “substantial increase in the cost of medical expense benefits,” the Legislature imposed “further controls on the use of those benefits, including the establishment of a basis for determining whether treatments or diagnostic tests are *medically necessary*.” *Id.* (emphasis added).

The New Jersey Legislature delegated to the state regulator the authority to define “medically necessary.” The regulator then worked with medical experts to formulate a definition of the term. *Id.* at 286. The

definition the regulator ultimately adopted has multiple elements, and incorporates “a series of medical protocols or care paths as the standard course of ‘medically necessary treatment’ for certain soft tissue injuries of the neck and back.” *Id.*; N.J.A.C. 11:3-4.2. “The care path regulations thus establish typical courses of treatment for certain common automobile-related injuries and serve as standards for measuring medical necessity ....” *Id.* In the case of a back sprain or strain, the care paths direct a maximum of twelve (12) weeks of conservative care before an “Independent Consultative Opinion” or IME. N.J.A.C.T. 11, Ch. 3, Subch. 4, 11:3-4 App.

Thus, New Jersey’s current “medically necessary” standard imposes a far stricter standard than the flexible MMI standard for “necessary.”

**5. State Farm Agrees that this Court Need Not Define “Necessary” In Resolving the Certified Questions**

Finally, State Farm agrees with Plaintiff that this Court need not define the term “necessary” in WAC 284-30-395 to resolve the certified questions presented here. (Brief, p. 19 fn. 5). All this Court needs to decide is whether “essential to achieving MMI” is consistent with the plain meaning of “necessary” in WAC 284-30-395. *Kintz*, 169 Wn.2d at 547. Clearly, it is.

If “necessary” should have some specialized definition that goes beyond its plain meaning, or that differs from the definition that the OIC repeatedly approved in State Farm’s form, the OIC is in the best position to make that decision. Given the practical and policy implications of changing such a highly-regulated area of law, the Court should defer to the OIC’s expertise on the issue. *Progressive Cas. Ins. Co. v. Jester*, 102 Wn.2d 78 (1984) (rejecting insured’s policy arguments and reasoning “we cannot require mandatory insurance where the Legislature has declined,” but noting that the OIC acted where the court could not by prospectively withdrawing approval of the policy form at issue); *Bain*, 175 Wn.2d at 109 (“The legislature, not this court, is in the best position to assess policy considerations.”).

## VI. CONCLUSION

For all of the foregoing reasons, State Farm respectfully requests that the Court find (1) that State Farm does not violate WAC 284-30-395 when it terminates an insured’s medical or hospital benefits based on a finding of MMI, and (2) that MMI is consistent with “necessary” as that term appears in WAC 284-30-395.

DATED this 6th day of October, 2017.

SHEPPARD MULLIN RICHTER & HAMPTON LLP

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**CERTIFICATE OF SERVICE**

I certify that I served a copy of the foregoing, Defendant's Response Brief, on the following individuals specified below on October 6, 2017. Service was made by the means specified below:

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Via ECF

DATED this 6th day of October, 2017.

  
\_\_\_\_\_  
Vicki Milbrad

# EXHIBIT 1

Washington Administrative Code  
Title 284. Insurance Commissioner, Office of  
Chapter 284-30. Trade Practices (Refs & Annos)  
the Unfair Claims Settlement Practices Regulation

WAC 284-30-395

284-30-395. Standards for prompt, fair and equitable settlements  
applicable to automobile personal injury protection insurance.

Currentness

The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions. To eliminate unfair acts or practices in accord with RCW 48.30.010, the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance specifically applicable to automobile personal injury protection insurance. The following standards apply to an insurer's consultation with health care professionals when reviewing the reasonableness or necessity of treatment of the insured claiming benefits under his or her automobile personal injury protection benefits in an automobile insurance policy, as those terms are defined in RCW 48.22.005 (1), (7), and (8), and as prescribed at RCW 48.22.085 through 48.22.100. This section applies only where the insurer relies on the medical opinion of health care professionals to deny, limit, or terminate medical and hospital benefit claims. When used in this section, the term "medical or health care professional" does not include an insurer's claim representatives, adjusters, or managers or any health care professional in the direct employ of the insurer.

(1) Within a reasonable time after receipt of actual notice of an insured's intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

- (a) Are not reasonable;
- (b) Are not necessary;
- (c) Are not related to the accident; or
- (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

The written explanation responsive to an insured's intent to file a personal injury protection medical and hospital benefits claim must also include contact information for the office of the Washington state insurance commissioner's consumer protection services, including the consumer protection division's hotline phone number and the agency's web site address,

and a statement that the consumer may contact the office of the insurance commissioner for assistance with questions or complaints.

(2) Within a reasonable time after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall provide an insured with a written explanation that describes the reasons for its action and copies of pertinent documents, if any, upon request of the insured. The insurer shall include the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.

(3) (a) Health care professionals with whom the insurer will consult regarding its decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured.

(b) If the insured is being treated by more than one health care professional, the review shall be completed by a professional licensed, certified, or registered to practice in the same health field or specialty as the principal prescribing or diagnosing provider, unless otherwise agreed to by the insured and the insurer. This does not prohibit the insurer from providing additional reviews of other categories of professionals.

(4) To assist in any examination by the commissioner or the commissioner's delegatee, the insurer shall maintain in the insured's claim file sufficient information to verify the credentials of the health care professional with whom it consulted.

(5) An insurer shall not refuse to pay expenses related to a covered property damage loss arising out of an automobile accident solely because an insured failed to attend, or chose not to participate in, an independent medical examination requested under the insured's personal injury protection coverage.

(6) If an automobile liability insurance policy includes an arbitration provision, it shall conform to the following standards:

(a) The arbitration shall commence within a reasonable period of time after it is requested by an insured.

(b) The arbitration shall take place in the county in which the insured resides or the county where the insured resided at the time of the accident, unless the parties agree to another location.

(c) Relaxed rules of evidence shall apply, unless other rules of evidence are agreed to by the parties.

(d) The arbitration shall be conducted pursuant to arbitration rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington Arbitration and Mediation Service, chapter 7.04 RCW, or any other rules of arbitration agreed to by the parties.

**Credits**

Statutory Authority: RCW 48.02.060 and 48.22.105. WSR 12-19-081 (Matter No. R 2012-13), § 284-30-395, filed 9/18/12, effective 4/1/13. Statutory Authority: RCW 48.02.060, 48.22.105 and 48.30.010. WSR 97-13-005 (Matter No. R 96-6), § 284-30-395, filed 6/5/97, effective 7/6/97.

Current with amendments adopted through the 17-15 Washington State Register dated, August 2, 2017.

WAC 284-30-395, WA ADC 284-30-395

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# EXHIBIT 2

West's Revised Code of Washington Annotated Title 48. Insurance (Refs & Annos) Chapter 48.22. Casualty Insurance (Refs & Annos)
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West's RCWA 48.22.005

48.22.005. Definitions

Currentness

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Automobile" means a passenger car as defined in RCW 46.04.382 registered or principally garaged in this state other than:

(a) A farm-type tractor or other self-propelled equipment designed for use principally off public roads;

(b) A vehicle operated on rails or crawler-treads;

(c) A vehicle located for use as a residence;

(d) A motor home as defined in RCW 46.04.305; or

(e) A moped as defined in RCW 46.04.304.

(2) "Bodily injury" means bodily injury, sickness, or disease, including death at any time resulting from the injury, sickness, or disease.

(3) "Income continuation benefits" means payments for the insured's loss of income from work, because of bodily injury sustained by the insured in an automobile accident, less income earned during the benefit payment period. The combined weekly payment an insured may receive under personal injury protection coverage, worker's compensation, disability insurance, or other income continuation benefits may not exceed eighty-five percent of the insured's weekly income from work. The benefit payment period begins fourteen days after the date of the automobile accident and ends at the earliest of the following:

(a) The date on which the insured is reasonably able to perform the duties of his or her usual occupation;

(b) Fifty-four weeks from the date of the automobile accident; or

(c) The date of the insured's death.

(4) "Insured automobile" means an automobile described on the declarations page of the policy.

(5) "Insured" means:

(a) The named insured or a person who is a resident of the named insured's household and is either related to the named insured by blood, marriage, or adoption, or is the named insured's ward, foster child, or stepchild; or

(b) A person who sustains bodily injury caused by accident while: (i) Occupying or using the insured automobile with the permission of the named insured; or (ii) a pedestrian accidentally struck by the insured automobile.

(6) "Loss of services benefits" means reimbursement for payment to others, not members of the insured's household, for expenses reasonably incurred for services in lieu of those the insured would usually have performed for his or her household without compensation, provided the services are actually rendered. The maximum benefit is forty dollars per day. Reimbursement for loss of services ends the earliest of the following:

(a) The date on which the insured person is reasonably able to perform those services;

(b) Fifty-two weeks from the date of the automobile accident; or

(c) The date of the insured's death.

(7) "Medical and hospital benefits" means payments for all reasonable and necessary expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident for health care services provided by persons licensed under Title 18 RCW, including pharmaceuticals, prosthetic devices and eyeglasses, and necessary ambulance, hospital, and professional nursing service. Medical and hospital benefits are payable for expenses incurred within three years from the date of the automobile accident.

(8) "Automobile liability insurance policy" means a policy insuring against loss resulting from liability imposed by law for bodily injury, death, or property damage suffered by any person and arising out of the ownership, maintenance, or use of an insured automobile. An automobile liability policy does not include:

(a) Vendors single interest or collateral protection coverage;

(b) General liability insurance; or

(c) Excess liability insurance, commonly known as an umbrella policy, where coverage applies only as excess to an underlying automobile policy.

(9) "Named insured" means the individual named in the declarations of the policy and includes his or her spouse if a resident of the same household.

(10) "Occupying" means in or upon or entering into or alighting from.

(11) "Pedestrian" means a natural person not occupying a motor vehicle as defined in RCW 46.04.320.

(12) "Personal injury protection" means the benefits described in this section and RCW 48.22.085 through 48.22.100. Payments made under personal injury protection coverage are limited to the actual amount of loss or expense incurred.

**Credits**

[2003 c 115 § 1, eff. July 27, 2003; 1993 c 242 § 1.]

**Notes of Decisions (4)**

West's RCWA 48.22.005, WA ST 48.22.005

The statutes are current with all effective legislation through the 2017 Third Special Session of the Washington legislature.

# EXHIBIT 3

It applies during a period that:

- a. begins on the 14th day after the date of the accident, and
  - b. ends either:
    - (1) when the *insured* is reasonably able to perform the duties of his or her usual occupation;
    - (2) 52 weeks after such 14th day begins; or
    - (3) on the date of the *insured's* death; whichever occurs first.
4. Loss of Services Benefits, which are payments for reasonable expenses actually incurred for services:
- a. the *insured* would have performed without pay for his or her household except for the injury;
  - b. furnished by someone other than a member of the *insured's* household; and
  - c. furnished during a period that:
    - (1) begins on the date of the accident; and
    - (2) ends either:
      - (a) when the *insured* is reasonably able to perform those services;
      - (b) 365 days after the date of the accident; or
      - (c) when the *insured* dies;
 whichever occurs first.

**Reasonable Medical Expenses** mean expenses:

- 1. that are the lowest one of the following charges:
  - a. The usual and customary fees charged by a majority of healthcare providers who provide similar medical services in the geographical area in which the charges were incurred;
  - b. The fee specified in any fee schedule:
    - (1) applicable to medical payments coverage, no-fault coverage, or personal injury protection coverage included in motor vehicle

liability policies issued in the state where *medical services* are provided; and

- (2) as prescribed or authorized by the law of the state where *medical services* are provided;
  - c. The fees agreed to by both the *insured's* healthcare provider and *us*; or
  - d. The fees agreed upon between the *insured's* healthcare provider and a third party when *we* have a contract with such third party.
2. incurred for necessary:
- a. medical, surgical, X-ray, dental, ambulance, hospital, and professional nursing services, and
  - b. pharmaceuticals, eyeglasses, hearing aids, and prosthetic devices
- that are rendered by or prescribed by a licensed medical provider within the legally authorized scope of the provider's practice and are essential in achieving maximum medical improvement for the *bodily injury* sustained in the accident.
- Subject to 1. and 2. above, semi-private room charges are the most *we* will pay unless intensive care is medically required.

**Insuring Agreement**

*We* will provide *personal injury protection benefits* to an *insured* for *bodily injury* sustained by that *insured* and caused by an *automobile* accident.

**Determining Reasonable Medical Expenses**

*We* have the right to:

- 1. obtain and use:
  - a. peer reviews; and
  - b. medical bill reviews
 of the medical expenses and services to determine if they are reasonable and necessary for the *bodily injury* sustained;
- 2. use a medical examination of the *insured* to determine if:

# EXHIBIT 4

STATE OF WASHINGTON

MIKE KREIDLER  
STATE INSURANCE COMMISSIONER



P.O. BOX 46255  
OLYMPIA, WA 98504-0255  
Phone: (360) 725-7000

OFFICE OF  
INSURANCE COMMISSIONER

\*\* Courtesy Copy via E-Mail \*\*

March 13, 2006

Actuarial Services

MAR 21 2006

State of Washington

STATE FARM  
ONE STATE FARM PLAZA D-4  
BLOOMINGTON IL 61710

ATTN: STEVE WOODARD ✓  
EVERETT TRUTTMANN

RE: STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY  
STATE FARM FIRE AND CASUALTY COMPANY  
PRIVATE AUTO REVISION  
COMPANY FILING NO.: AV 20476

SUSPENSE DATE: MAY 13, 2006

Thank you for your letter of February 13, 2006, concerning the captioned filing. We continue to hold certain of your forms as disapproved. Please respond to the following:

Forms 6184FF, 6235R, 6018K, 6030M.1, 6075JJ.5, 6055Z.1, 6054F.2, 6057S, 6062R, 6066N, 6067N, 6068MM, 6071C.2, 6080R, 6084EE, 6164JJ.1, 6165Z.2, 6166ZZ, 6169J.3, and 6198Q.2

These forms are for commercial auto use, not personal auto. All forms in a filing should be used for the same program. Your commercial auto forms need to be filed separately. Please provide a revised form filing schedule for the personal auto form filing.

Form 6028BJ and 6097.AR.1

An additional insured or anyone with interest in the policy must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty days that the contract has been in effect. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any additional insureds.

Form 6037V

A certificate holder must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty days of the contract's effective date. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any additional insureds.

Form 6091T

If this form, or any other forms in the filing, is used only by State Farm Mutual Automobile Insurance

Company, they need to be filed in a separate filing for State Farm Mutual Automobile Insurance Company. All forms contained in a filing must be used by all of the companies you are filing on behalf.

**Form 6023YY.1 and 6105BB.1**

If an excluded driver is operating an insured vehicle, the vehicle may be both uninsured and underinsured. You must provide underinsured motorist coverage when an excluded driver operates a vehicle. Please review First National Insurance Company of America v. Perala, 32 Wn.App. 527, 648 P.2d. 472, and amend your form.

RCW 48.22.085 requires Personal Injury Protection (PIP) coverage unless the named insured rejects PIP coverage in writing. RCW 48.22.095 says you must offer personal injury protection to "each insured." Any person who qualifies as an "insured" under RCW 48.22.005(5) must be provided PIP coverage, even if the vehicle is being operated by an excluded driver.

**Form 6049AN**

RW 48.22.085 requires that no new auto liability insurance policies or renewals of such existing policies be issued unless PIP coverage is offered as an optional coverage. If the coverage is purchased, you must provide the coverages outlined under the PIP statutes. The only exception would be the regular use exclusions under RCW 48.22.090(5) and (6). Our statutes do not allow for deviation from them because the car is not owned.

**Form 6182T**

It is unclear what this endorsement is used for. Please provide an explanation of how and when this endorsement will be used.

**Form 6279BW**

Please indicate if there has been a rating rule filed for the seasonal premium adjustment table in this endorsement.

**Form 6289S.2**

This form should be consistent with the language used in your policy on pages 22, 23 and 27 of your policy to avoid being misleading.

**Form 6230FF**

Your limit of \$10 per day for a rental car through a rental agency seems extremely low and potentially unavailable to an insured that purchases this coverage. Does State Farm know of a rental car agency willing to rent a car for \$10 a day?

**Form 6289CS**

This form contains language that is different from language in your policy under Required Out of State Liability coverage on page 10 and is misleading.

**Form 6123W.1**

It is unclear how PIP coverage will apply on special equipment. Special equipment is not defined in this endorsement and does not fit under RCW 48.22.005(1). Our statutes do not allow for a deviation from them so if PIP is provided on this coverage, it would have to follow the statutes exactly.

**Form 9847A**

**1. Liability Coverage, Insuring Agreement (1)(a)(2) Damage to Property**

The coverage for loss of use has been deleted from your new policy edition. It is unclear why this was deleted. This is something that the insured would be legally liable for.

**2. Liability Coverage, Exclusions (8)**

It is unclear how this exclusion will be applied. Will this exclusion include the insured's vehicle? Are you excluding coverage only on those vehicles that an insured parks in a business setting and as part of their profession? This is not clear in the policy.

**3. Personal Injury Protection, Reasonable Fees (b) Fee Schedule**

Please provide an explanation of "fee schedule" as used in your policy.

**4. Personal Injury Protection, Arbitration (6)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

**5. Medical Payments Coverage, Arbitration (6)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

**6. Underinsured Motor Vehicle Bodily Injury Coverage, Additional Definitions, Insured**

You must provide UIM coverage to everyone who is a covered person under the liability section of your policy. Please review RCW 48.22.030, Rau v. Liberty Mutual Insurance Company, 21 Wn. App. 326; 585 P.2d 157 and Financial Indemnity Company v. Keomaneethong, 85 Wn. App. 350; 931 P.2d 168. Please amend your definition so it is as broad as the coverage provided in the liability section of your policy.

**7. Underinsured Motor Vehicle Bodily Injury Coverage, Additional Definitions, Underinsured Motor Vehicle (1)(b)(1) and UIM Property Damage, Additional Definitions, Underinsured Motor Vehicle (1)(b)(1)**

Washington UIM statutes do not refer to, nor do they limit coverage to the Washington Financial Responsibility Act. Please revise your definition of an underinsured motor vehicle to comply with RCW 48.22.030(1).

Please note, SHB 2415 has been adopted. Your definition of "accident" for UIM will need to be revised to comply with RCW 48.22.030(11). This bill is effective June 7, 2006, therefore, you need to incorporate the new sections of this bill into this filing.

**8. Underinsured Motor Vehicle Bodily Injury Coverage and Underinsured Motor Vehicle Property Damage Coverage, Notice of Tentative Settlement (2)(b)**

This condition does not comply with Washington case law as described in Bulletin 79-4. This Bulletin is based upon Thiringer v. American Motors Ins. Co., 91 Wn. 2d 215. The Supreme Court stated the insured is entitled to complete reimbursement for loss before the company is entitled to subrogation proceeds.

**9. Underinsured Motor Vehicle Bodily Injury Coverage and Underinsured Motor Vehicle Property Damage Coverage, Deciding Fault and Amount (2)**

Your form should clarify that you are not bound by any default judgment against any other person or organization unless you have notice of the litigation and do nothing. Please see Hamilton vs. Farmers Ins. Co. 107 Wn2d 721, 733 P.2d 213.

**10. Underinsured Motor Vehicle Bodily Injury Coverage, Nonduplication**

Non duplication provisions are okay, however, you should state that the insured must be fully compensated first. Please see Hamm vs. State Farm.

**11. Underinsured Motor Vehicle Property Damage Coverage, Insuring Agreement**

You will pay a claim only after the limits of liability under all applicable liability policies or bonds have been exhausted. According to our Attorney General in AGO 1981 No. 13, and Elovich v. Nationwide Insurance Company, 104 Wn.2d 543, 707 P.2d 1319, "exhaustion clauses" are not enforceable because underinsured motorist coverage floats above all available liability coverage. You must amend your form.

**12. Underinsured Motor Vehicle Property Damage Coverage, If Other Underinsured Motor Vehicle Property Damage Coverage Applies**

Your policy should clarify that if the vehicle is listed under this policy, your coverage for physical damage would be primary. RCW 48.22.030 does not allow for any coverage under UIM to be secondary.

**13. Physical Damage Coverage, Limits and Loss Settlement (b)(1)(f)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

**14. Physical Damage Coverage, Limits and Loss Settlement (2)**

Please provide what rate filing the new \$500 limit for fungi was approved in by our agency.

**15. Physical Damage Coverage, Financed Vehicle**

A creditor must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty

days that the contract has been in effect. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any one else with interest in the policy.

**16. Insured's Duties, Notice to Us of an Accident or Loss**

Your form indicates the insured must notice to you of every demand, notice, claim, summons and legal process received. What if your insured is hospitalized and can't? What action will be taken if the insured does not comply with these requirements?

**17. Insured's Duties, Questioning Under Oath**

You may require each person or organization answering questions under oath to answer them with only that person's or organization's legal representative. What is the purpose or need of this? A person or organization you are questioning may require additional people for assistance outside a legal representative. If State Farm has 10 people in a room conducting questions under oath, a person or organization should be allowed the same benefit as State Farm.

**18. Insured's Duties, (6)**

Please note, SHB 2415 has been adopted. This bill is effective June 7, 2006, therefore, you need to incorporate the new sections of this bill into this filing.

**19. General Terms, (7) Nonrenewal**

Under RCW 48.18.292, you must include the "actual reason" for your nonrenewal.

**20. General Terms, (8) Cancellation**

**a. How You May Cancel**

You require the insured to give you advance notice to cancel the policy. This does not comply with RCW 48.18.300(1), which states that the insured must give notice to the insurer "prior to or on the effective date of such cancellation."

**b. How and When We May Cancel**

Under RCW 48.18.291(1), you must provide the reason you are canceling the policy.

**21. General Terms, Legal Action Against Us (13)**

If State Farm denies a claim or otherwise breaches the contract, Washington's contract statute, RCW 4.16.040, would apply. RCW 4.16.040 allows legal action up to six years for an action upon a contract in writing.

Upon receipt of your response we will reconsider your filing. If we do not receive a reply by the **SUSPENSE DATE** shown above, your filing will be closed, and we will reconsider the disapproved forms only if you

State Farm  
March 13, 2006  
Page Six

resubmit a new filing for them.

Sincerely,

A handwritten signature in cursive script that reads "Michelle Beck". The signature is written in black ink and extends across the width of the page.

MICHELLE BECK  
Insurance Policy and Compliance Analyst I  
Rates and Forms Division  
(360) 725-7116  
E-mail: michellb@oic.wa.gov

**State Farm®**  
Providing Insurance and Financial Services  
Home Office, Bloomington, Illinois 61710



May 2, 2006

Insurance Commissioner  
Office of Insurance Commissioner  
5000 Capitol Boulevard  
Turnwater, WA 98501

**Corporate Headquarters**  
One State Farm Plaza, D-4  
Bloomington, IL 61710  
Fax 309 766 0225

Attn: Michelle Beck  
Insurance Policy and Compliance Analyst I, Rates & Forms Division

IN REPLY PLEASE REFER TO: AV-20476  
Filing of December 21, 2005

RE: State Farm Mutual Automobile Insurance Company  
State Farm Fire and Casualty Company  
Automobile Insurance  
9847A – State Farm Car Policy Booklet  
155-3866.2 - Declarations Page  
Associated Endorsements

We are enclosing new copies of Car Policy Booklet 9847A, endorsements 6018Q (which replaces previously filed 6018K), 6023YY.1, 6028BL, 6097AR.1, 6105BB.1, and 6289S.2, the comparison for 9847A, and the comparison for the miscellaneous endorsements. These forms and comparisons have been revised as described below in our responses to your questions and comments from your letter of March 13, 2006.

**Forms 6184FF, 6235R, 6018K, 6030M.1, 6075JJ.5, 6055Z.1, 6054F.2, 6057S, 6062R, 6066N, 6067N, 6068MM, 6071C.2, 6080R, 6084EE, 6164JJ.1, 6165Z.2, 6166ZZ, 6169J.3, and 6198Q.2**

These forms are for commercial auto use, not personal auto. All forms in a filing should be used for the same program. Your commercial auto forms need to be filed separately. Please provide a revised form filing schedule for the personal auto form filing.

A separate personal auto form filing has been sent with this response. Endorsements 6068MM, 6071C.2, and 6169J.3 can be used for both commercial and personal auto use and will be shown in both filings.

**Form 6028BJ and 6097.AR.1**

An additional insured or anyone with interest in the policy must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty days that the contract has been in effect. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any additional insureds.

We have revised these endorsements by adding the phrase "unless another notice period is required by law."

### **Form 6037V**

A certificate holder must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty days of the contract's effective date. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any additional insureds.

The form as filed has a blank for completion where the number of days for notice is to be shown. The correct number of days will be written in based upon the vehicle type or the request of the certificate holder.

### **Form 6091T**

If this form, or any other forms in the filing, is used only by State Farm Mutual Automobile Insurance Company, they need to be filed in a separate filing for State Farm Mutual Automobile Insurance Company. All forms contained in a filing must be used by all of the companies you are filing on behalf.

This endorsement has been moved to our State Farm Mutual filing AV 20610.

### **Form 6023YY.1 and 6105BB.1**

If an excluded driver is operating an insured vehicle, the vehicle may be both uninsured and underinsured. You must provide underinsured motorist coverage when an excluded driver operates a vehicle. Please review First National Insurance Company of America v. Perala, 32 Wn.App. 527, 648 P.2d. 472, and amend your form.

RCW 48.22.085 requires Personal Injury Protection (PIP) coverage unless the named insured rejects PIP coverage in writing. RCW 48.22.095 says you must offer personal injury protection to "each insured." Any person who qualifies as an "insured" under RCW 48.22.005(5) must be provided PIP coverage, even if the vehicle is being operated by an excluded driver.

These forms have been revised so that only the excluded driver is excluded from PIP and the Underinsured Motor Vehicle Coverages.

### **Form 6049AN**

RW 48.22.085 requires that no new auto liability insurance policies or renewals of such existing policies be issued unless PIP coverage is offered as an optional coverage. If the coverage is purchased, you must provide the coverages outlined under the PIP statutes. The only exception would be the regular use exclusions under RCW 48.22.090(5) and (6). Our statutes do not allow for deviation from them because the car is not owned.

The endorsement provides an extension of coverage from an existing car policy for which the named insured has already selected or rejected PIP.

### **Form 6182T**

It is unclear what this endorsement is used for. Please provide an explanation of how and when this endorsement will be used.

This endorsement is attached to policies upon request of the named insured to broaden Liability Coverage by substituting "occurrence" for "accident." Requests usually confined to commercial or fleet risks.

### **Form 6279BW**

Please indicate if there has been a rating rule filed for the seasonal premium adjustment table in this endorsement.

Yes.

### Form 6289S.2

This form should be consistent with the language used in your policy on pages 22, 23 and 27 of your policy to avoid being misleading.

This form has been so revised and the new version is enclosed.

### Form 6230FF

Your limit of \$10 per day for a rental car through a rental agency seems extremely low and potentially unavailable to an insured that purchases this coverage. Does State Farm know of a rental car agency willing to rent a car for \$10 a day?

This is an old coverage that we are removing from the policy booklet and that we expect to discontinue with our next rate filing. The endorsement is provided to maintain a coverage that insureds had selected in the past. The \$10 a day is not meant to cover a rental car. The language of the endorsement indicates that we are reimbursing up to \$10 for any substitute transportation.

### Form 6289CS

This form contains language that is different from language in your policy under Required Out of State Liability coverage on page 10 and is misleading.

This endorsement is placed on policies at the request of the named insured to provide a single limit for Liability Coverage. The language of the endorsement in question is added to provide split limits if that is required by a financial responsibility law, etc. The Required Out of State provision gives us the ability to increase the amount of the limits for Liability Coverage if so required by the laws of that other state. The two then are used for different purposes and are not meant to be applied in the same manner.

### Form 6123W.1

It is unclear how PIP coverage will apply on special equipment. Special equipment is not defined in this endorsement and does not fit under RCW 48.22.005(1). Our statutes do not allow for a deviation from them so if PIP is provided on this coverage, it would have to follow the statutes exactly.

Special equipment is equipment that is transported by or attached to the vehicle for use in the business of the insured, such as a tar pot or a hoist. We are excluding PIP coverage for this equipment when it is being used for purposes other than transportation. We believe that the law does not require us to provide PIP coverage while this equipment is being used for such other purposes.

### Form 9847A

#### **1. Liability Coverage, Insuring Agreement (1)(a)(2) Damage to Property**

The coverage for loss of use has been deleted from your new policy edition. It is unclear why this was deleted. This is something that the insured would be legally liable for.

We removed "including its loss of use," because we viewed the language as redundant. We believe that loss of use falls within "damages an *insured* becomes legally liable to pay because of ... damage to property."

#### **2. Liability Coverage, Exclusions (8)**

It is unclear how this exclusion will be applied. Will this exclusion include the insured's vehicle?

The "valet" exclusion applies to a person, who might otherwise be an "insured" as defined for liability coverage. Coverage is excluded when that insured is employed to "valet park" vehicles. Because "valet parking" may be offered by restaurants or businesses that may not be considered

"car businesses", (for which coverage is clearly excluded) we want to make it clear that no liability coverage is afforded from our policy, to a person engaged in this business related activity. Liability coverage for the person engaged in parking the vehicle should be provided by the business offering the valet service.

Are you excluding coverage only on those vehicles that an insured parks in a business setting and as part of their profession? This is not clear in the policy.

We believe this exclusion makes it clear that no insured has coverage while "valet parking" any vehicle.

### **3. Personal Injury Protection, Reasonable Fees (b) Fee Schedule**

Please provide an explanation of "fee schedule" as used in your policy.

Certain states provide in their law that certain treatments and procedures can only be billed at or below certain amounts determined by the state or some other organization prescribed by the state.

### **4. Personal Injury Protection, Arbitration (6)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

The language in question is meant to inform the insured that we are not waiving any rights by agreeing to the arbitration. It is not meant to imply that the insured is waiving any rights. Since this is a concern, we are revising the language to state that neither us nor the insured is waiving any rights by agreeing to the arbitration.

### **5. Medical Payments Coverage, Arbitration (6)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

See answer to 4 above.

### **6. Underinsured Motor Vehicle Bodily Injury Coverage, Additional Definitions, Insured**

You must provide UIM coverage to everyone who is a covered person under the liability section of your policy. Please review RCW 48.22.030, Rau v. Liberty Mutual Insurance Company, 21 Wn. App. 326; 585 P.2d 157 and Financial Indemnity Company v. Keomaneethong, 85 Wn. App. 350; 931 P.2d 168. Please amend your definition so it is as broad as the coverage provided in the liability section of your policy.

The definition of insured in UIM coverage is actually broader than that of the Liability Coverage since there is no restriction in the UIM definition regarding vehicles. It is not until the owned but not insured exclusion (Exclusion #1) that a restriction is placed on vehicles occupied, and the same people who are provided additional Liability Coverage by #2 of the Liability Coverage definition of insured are excepted out of the UIM owned but not insured exclusion (#1.a.). We believe then that we are in compliance.

### **7. Underinsured Motor Vehicle Bodily Injury Coverage, Additional Definitions, Underinsured Motor Vehicle (1)(b)(1) and UIM Property Damage, Additional Definitions, Underinsured Motor Vehicle (1)(b)(1)**

Washington UIM statutes do not refer to, nor do they limit coverage to the Washington Financial Responsibility Act. Please revise your definition of an underinsured motor vehicle to comply with RCW 48.22.030(1).

We have revised the language accordingly.

Please note, SHB 2415 has been adopted. Your definition of "accident" for UIM will need to be revised to comply with RCW 48.22.030(11). This bill is effective June 7, 2006, therefore, you need to incorporate the new sections of this bill into this filing.

We do not define "accident" in our policy. Therefore, the definition in the law would apply.

**8. Underinsured Motor Vehicle Bodily Injury Coverage and Underinsured Motor Vehicle Property Damage Coverage, Notice of Tentative Settlement (2)(b)**

This condition does not comply with Washington case law as described in Bulletin 79-4. This Bulletin is based upon Thiringer v. American Motors Ins. Co., 91 Wn. 2d 215. The Supreme Court stated the insured is entitled to complete reimbursement for loss before the company is entitled to subrogation proceeds.

The Notice of Tentative Settlement provision and the revised Deciding Fault and Amount provision were approved by you as part of endorsement 6947.2 (our filing number AV-18170 with original filing date July 26, 2004) after our explanation that it "puts into writing the settlement process and concept enunciated by the WA Supreme Court in Hamilton v. Farmers Ins. Co., 107 Wn2d 721 (1987)."

**9. Underinsured Motor Vehicle Bodily Injury Coverage and Underinsured Motor Vehicle Property Damage Coverage, Deciding Fault and Amount (2)**

Your form should clarify that you are not bound by any default judgment against any other person or organization unless you have notice of the litigation and do nothing. Please see Hamilton vs. Farmers Ins. Co. 107 Wn2d 721, 733 P.2d 213.

Please see above.

**10. Underinsured Motor Vehicle Bodily Injury Coverage, Nonduplication**

Non duplication provisions are okay, however, you should state that the insured must be fully compensated first. Please see Hamm vs. State Farm.

We agree that the insured must be fully compensated before we are reimbursed. In fact, we have an express provision to that effect found in the last paragraph on page 44 of the proposed Washington Car Policy, under the General Terms provision. The purpose of the Non-duplication provision is to prevent the payment of the same, identical expense twice (e.g., duplicate payment of the same doctor's bill). This position is consistent with the Washington Supreme Court's "...[guiding] principle that a party suffering compensable injury is entitled to be made whole but should not be allowed to duplicate his recovery." Leader National Insurance Company v. Torres, 113 Wn.2d 366, 369 (1989).

**11. Underinsured Motor Vehicle Property Damage Coverage, Insuring Agreement**

You will pay a claim only after the limits of liability under all applicable liability policies or bonds have been exhausted. According to our Attorney General in AGO 1981 No. 13, and Elovich v. Nationwide Insurance Company, 104 Wn.2d 543, 707 P.2d 1319, "exhaustion clauses" are not enforceable because underinsured motorist coverage floats above all available liability coverage. You must amend your form.

The provision as written has been removed. We have returned a revised exclusion to the policy which now reads:

THERE IS NO COVERAGE:

1. TO THE EXTENT THE **INSURED** HAS COLLECTED OR MAY COLLECT FROM ANY OF THE PHYSICAL DAMAGE COVERAGES OF THIS POLICY OR FROM ANY PROPERTY INSURANCE OF ANOTHER POLICY.

**12. Underinsured Motor Vehicle Property Damage Coverage, If Other Underinsured Motor Vehicle Property Damage Coverage Applies**

Your policy should clarify that if the vehicle is listed under this policy, your coverage for physical damage would be primary. RCW 48.22.030 does not allow for any coverage under UIM to be secondary.

This provision has been revised. See the new exclusion language shown above.

**13. Physical Damage Coverage, Limits and Loss Settlement (b)(1)(f)**

This condition does not fairly treat your insureds. You state you will not waive any of your rights by any act relating to arbitration. The same provision should also apply to insureds. If you intend to maintain an arbitration condition, the acts of the arbitrator should be equally binding on all parties. Please remove the last sentence of this condition or modify it to include the named insured.

The language in question is meant to inform the insured that we are not waiving any rights by agreeing to the appraisal. It is not meant to imply that the insured is waiving any rights. Since this is a concern, we are revising the language to state that neither us nor the insured is waiving any rights by agreeing to the appraisal.

**14. Physical Damage Coverage, Limits and Loss Settlement (2)**

Please provide what rate filing the new \$500 limit for fungi was approved in by our agency.

Our filing numbers were SFMPPA03-1, SFFPPA03-1, SFMCOMM03-1, and SFFCOMM03-1 which were approved effective January 25, 2004.

**15. Physical Damage Coverage, Financed Vehicle**

A creditor must be given the same amount of notice on cancellation or nonrenewal that the insured is given. Ten days written notice is sufficient on an auto policy for nonpayment of premium or if it is within the first thirty days that the contract has been in effect. If the policy is cancelled or nonrenewed for other reasons, twenty days written notice must be given to the insured and any one else with interest in the policy.

For private passenger automobiles (as defined per RCW 48.18.297), we will follow notice requirements of RCW 48.18.291 as currently set out in Car Policy 9847A. For all other types of vehicles, we will follow the notice requirements of RCW 48.18.290. See endorsement 6018Q attached to such other vehicles' policies to provide for such notice.

**16. Insured's Duties, Notice to Us of an Accident or Loss**

Your form indicates the insured must notice to you of every demand, notice, claim, summons and legal process received. What if your insured is hospitalized and can't? What action will be taken if the insured does not comply with these requirements?

This language, or something similar in meaning, is not new and has been a part of our current and previous Washington car policies. Your Department has approved this type of language in the past. The purpose of the language is not to deny the claims of those who are unable to report their claims because of hospitalization or other exigent circumstances, but rather to enable us to have recourse against those individuals who have the opportunity to give us timely notice but do not do so. Without this policy language, we have no contractual basis to defend our right to conduct timely investigations of the accidents, to preserve evidence in a timely fashion, and to prepare appropriate defenses against third-party claims.

**17. Insured's Duties, Questioning Under Oath**

You may require each person or organization answering questions under oath to answer them with only that person's or organization's legal representative. What is the purpose or need of this? A person or organization you are questioning may require additional people for assistance outside a legal

representative. If State Farm has 10 people in a room conducting questions under oath, a person or organization should be allowed the same benefit as State Farm.

We are adding this language to combat fraudulent claims by keeping interested parties out of the room where they can coach each other or learn the answers given by each other.

#### **18. Insured's Duties, (6)**

Please note, SHB 2415 has been adopted. This bill is effective June 7, 2006, therefore, you need to incorporate the new sections of this bill into this filing.

We will add the following language to the Underinsured Motor Vehicle Coverage Duties:

If an insured is the intended victim of a tortfeasor, that insured must report the incident to the appropriate law enforcement agency and cooperate with any related law enforcement investigation.

#### **19. General Terms, (7) Nonrenewal**

Under RCW 48.18.292, you must include the "actual reason" for your nonrenewal.

This provision has been revised.

#### **20. General Terms, (8) Cancellation**

##### **a. How You May Cancel**

You require the insured to give you advance notice to cancel the policy. This does not comply with RCW 48.18.300(1), which states that the insured must give notice to the insurer "prior to or on the effective date of such cancellation."

This provision has been revised.

##### **b. How and When We May Cancel**

Under RCW 48.18.291(1), you must provide the reason you are canceling the policy.

This provision has been revised.

#### **21. General Terms, Legal Action Against Us (13)**

If State Farm denies a claim or otherwise breaches the contract, Washington's contract statute, RCW 4.16.040, would apply. RCW 4.16.040 allows legal action up to six years for an action upon a contract in writing.

RCW § 48.18.200 specifically provides that "no insurance contract ... shall contain any condition, stipulation, or agreement ... (c) limiting right of action against the insurer to a period of less than one year from the time when the cause of action accrues." Our proposed **Legal Action Against Us** provisions comply with this statute.

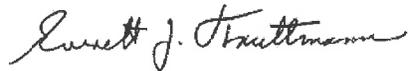
We hope that these revisions and response are acceptable and that you can now approve this filing in its entirety.

In an effort to work with you as promptly as possible, please direct any questions to:

Steve Woodard	(309) 766-2041	steve.woodard.a6bo@statefarm.com
Everett Truttmann	(309) 766-2066	everett.j.truttmann.awmz@statefarm.com

Please send paper correspondence to the attention of the State Filings Unit at the address shown above.

Sincerely,



Everett J. Truttmann, F.C.A.S., MAAA  
AVP & Actuary and Assistant Secretary-Treasurer

DE/bl  
Attachment

# EXHIBIT 5

1  
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6  
7 UNITED STATES DISTRICT COURT  
8 FOR THE WESTERN DISTRICT OF WASHINGTON  
9 AT SEATTLE

10 BRETT DURANT, On Behalf of Himself  
11 and all other similarly situated,

12 Plaintiff,

13 v.

14 STATE FARM MUTUAL  
15 AUTOMOBILE INSURANCE  
16 COMPANY, a foreign automobile  
17 insurance company,

18 Defendant.

Case No.: 2-15-CV-01710-RAJ

**CLASS ACTION**

**STIPULATION AND ~~[PROPOSED]~~  
ORDER REGARDING CLASS  
DEFINITION**

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**STIPULATION**

Plaintiff Brett Durant ("Plaintiff") and Defendant State Farm Mutual Automobile Insurance Company ("State Farm"), by and through counsel undersigned, hereby submit this *Stipulation and [Proposed] Order Regarding Class Definition* with respect to the following facts:

WHEREAS, on March 9, 2017, the Court issued its Order granting Plaintiff's Motion for Class Certification based on the class definition contained in Plaintiff's Complaint filed in this action;

1  
2 WHEREAS, on July 10, 2017, the Court issued its Order denying State Farm's  
3 Motion for Reconsideration of the Court's Order granting class certification;

4 WHEREAS, in its July 10 Order, the Court instructed the parties to file a stipulation  
5 containing any "agreed upon narrower language for the class definition" within 45 days  
6 of the date of the July 10 Order; and

7 WHEREAS, the parties have met and conferred in response to the Court's  
8 instruction;

9 The parties agree that the class definition should be narrowed to include only the  
10 following members:

11 "State Farm insureds in the state of Washington who, from  
12 April 19, 2008 to the present, had a Personal Injury Protection  
13 (PIP) claim for medical or hospital benefits denied,  
14 terminated or limited by State Farm Mutual Automobile  
15 Insurance Company (State Farm) on the grounds that they had  
16 reached Maximum Medical Improvement, using an  
17 Explanation of Review form referencing Reason Codes  
18 SF546 or SF537;" and

19 The parties further agree that State Farm does not waive, and expressly reserves,  
20 its rights to contest and appeal any orders relating to class certification in this action.

21 IT IS SO STIPULATED.

22 **ORDER**

23 Based on the Stipulation set forth above, and good cause appearing therefore,

24 IT IS HEREBY ORDERED that the class definition set forth in the Complaint is  
amended as follows:

State Farm insureds in the state of Washington who, from April 19,  
2008 to the present, had a Personal Injury Protection (PIP) claim for

1 medical or hospital benefits denied, terminated or limited by State  
2 Farm Mutual Automobile Insurance Company (State Farm) on the  
3 grounds that they had reached Maximum Medical Improvement,  
4 using an Explanation of Review form referencing Reason Codes  
5 SF546 or SF537.

6 DATED this the 30th day of August, 2017.

7   
8

9 The Honorable Richard A. Jones  
10 United States District Judge  
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**From:** ECF@wawd.uscourts.gov  
**To:** ECF@wawd.uscourts.gov  
**Subject:** Activity in Case 2:15-cv-01710-RAJ Durant v. State Farm Mutual Automobile Insurance Company Stipulation and Order  
**Date:** Wednesday, August 30, 2017 2:33:46 PM

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**U.S. District Court**

**United States District Court for the Western District of Washington**

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**Case Name:** Durant v. State Farm Mutual Automobile Insurance Company

**Case Number:** 2:15-cv-01710-RAJ

**Filer:**

**Document Number:** 82

**Docket Text:**

**STIPULATION AND ORDER Regarding Class Definition signed by Judge Richard A Jones. (TH)**

**2:15-cv-01710-RAJ Notice has been electronically mailed to:**

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9301a3075203e4658c48f363b5ef23eb10b2f038417ce88bff8adcad2d4ab]]

**LEWIS BRISBOIS BISGAARD & SMITH LLP**

**October 06, 2017 - 4:13 PM**

**Transmittal Information**

**Filed with Court:** Supreme Court  
**Appellate Court Case Number:** 94771-6  
**Appellate Court Case Title:** Brett Durant v. State Farm Mutual Automobile Insurance Company

**The following documents have been uploaded:**

- 947716\_Briefs\_20171006161044SC352646\_0582.pdf  
This File Contains:  
Briefs - Attorneys Response Brief  
*The Original File Name was Durant Defendant Response Brief.pdf*

**A copy of the uploaded files will be sent to:**

- jhoffman@sheppardmullin.com
- davidnauheim@gmail.com
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- ffalzetta@sheppardmullin.com
- laura.young@lewisbrisbois.com
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Sender Name: Colette Saunders - Email: colette.saunders@lewisbrisbois.com

**Filing on Behalf of:** Gregory S. Worden - Email: Gregory.Worden@lewisbrisbois.com (Alternate Email: vicki.milbrad@lewisbrisbois.com)

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