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NO. 96561-7

IN THE SUPREME COURT FOR THE
STATE OF WASHINGTON

(COA No. 76448-9-I)

FOLWEILER CHIROPRACTIC, PS, a Washington corporation,

Plaintiff-Respondent,

v.

AMERICAN FAMILY INSURANCE COMPANY,

Defendant-Petitioner.

PLAINTIFF-RESPONDENT'S RESPONSE TO PETITION FOR REVIEW

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I. IDENTITY OF RESPONDING PARTY

Respondent is Folweiler Chiropractic, LLC and its owner, Dr. David Folweiler, a Seattle chiropractor with 23 years of experience, a Diplomate of the Board of Chiropractic Rehabilitation ("Board Certified"), and who specializes in treating auto accident injuries.[1]

II. INTRODUCTION

Dr. Folweiler treated auto accident patients who had Personal Injury Protection ("PIP") coverage with Petitioner American Family Ins. Co. ("Am. Fam.").[2] The PIP statute requires that insurers provide $10,000 in "hospital and medical benefits" and defines that term as "payments for all reasonable and necessary" medical expenses from a covered accident. RCW 48.22.095; .005(7). The legislature intended that the PIP statute provide broad coverage for treatment expenses. *Durant v. State Farm Mut. Ins. Co.,* 191 Wn.2d 1, 14, 419 P.3d 400 (2018)("This regulation (WAC 284-30-395) and the noted statutes (RCW 48.22.095; .005(7)) reflect Washington's strong public policy in favor of the full compensation of medical benefits for victims of road accidents.")

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[1] *See* Folweiler/ Am. Fam. Letter, CP 410 attached as **Appendix A**.
[2] *See,* Complaint at ¶ 3.2, CP 2, attached for convenience as **Appendix B.**

The terms “all,” “reasonable” and “necessary” are not defined and are given their dictionary meaning. *Durant* at 11. “All” means “*Every, all manner, all kinds.*”[3] So under the PIP statute “payments of (every, all manner, all kinds) of reasonable” expenses must be made. Insurers cannot limit payments by overly restrictive definitions of what is a “reasonable” expense. *Durant* at 14-15.

But Am. Fam. does just that. It restricts “*all* reasonable” to only those provider expenses below the 85th percentile of the FAIR Health (“FH”) database of charges for a procedure from a broad geographic area of Washington. It *automatically denies* payment of *any* charge, by *any* provider, from *any* area, for *any* treatment, for *any* patient that is above the 85th percentile limit.[4] It denies payment no matter the provider’s years of experience, credentials, training, specialization or attributes and no matter if the area is a high-cost area in Seattle or a low-cost unincorporated area. It denies payment, *automatically,* no matter what the treatment involved for the extent of injury, the patient’s age or pre-existing injuries. *Id.*

Am. Fam. asked Dr. Folweiler to send his bills to it to pay and accepted them as a PIP claim for payment of all reasonable

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[3] *See,* American Heritage Dictionary (2nd College ed. 1982) at 94, definition 4.
[4] *See,* Am. Fam. Petition at 7; Folweiler Opening Brief in Court of Appeals at 10.

expenses incurred by the insured.[5] Its practice benefits Am. Fam. by ensuring accurate billing on PIP claims, but not providers like Dr. Folweiler who had to take time away from his practice and incur staff costs to submit his bills. Am. Fam. then denied his reasonable bills and he had to appeal. He then had to file a complaint with the Insurance Commissioner to get paid and waited months to be paid.

Am. Fam. denied payment of his reasonable bills based *solely* on a computer review by a third-party (AIS) that showed his fees were more than the amount set by the 85th percentile of charges for the same procedure in the FH database. The adjuster denied payment *without* investigating if Dr. Folweiler's rates were reasonable for *him* to bill for *his services.* The adjuster made no determination that his rates were unreasonable for a board certified chiropractor in a high-cost area of Seattle with over 20 years of practice and who specialized in treating auto accident injuries. The adjuster automatically denied payment and sent him a reduced check at the 85th percentile amount set by the computer.[6]

The regulations enforcing the PIP statute's requirement that insurers make "payments of all reasonable" medical expenses state

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[5] *See,* Complaint, CP 3, **Appendix B.**
[6] *See,* Petition at 7; Folweiler's Opening Brief in the Court of Appeals at 3,10.

that it is an unfair claims practice for an insurer to deny payment of a PIP claim "without" *first* conducting a reasonable investigation of the charges being billed. WAC 284-30-330. The regulations also state that it is an unfair practice for an insurer to deny payment "without" *first* actually determining that the billed charge is either not reasonable, the treatment was not necessary or the injury is not covered. WAC 284-30-395(1); *Durant, supra.* at 18.

Dr. Folweiler filed suit against Am. Fam. alleging that its practice of using a third-party's computer to *automatically* deny payment of his reasonable bills based solely on the 85th percentile amount and *without* investigating if the fee was reasonable for *him to bill for his services* violated WAC 284-30-330. He alleged that Am. Fam's practice of *automatically* denying his bills *without* determining his fee was an unreasonable amount for a board-certified chiropractor with similar years of experience and training in his high-cost area of Seattle violated WAC 284-30-395(1).

He alleged that Am. Fam's practice was a *non-per se* unfair Consumer Protection Act ("CPA") practice because it violated "Washington's strong public policy in favor of the *full compensation* of medical benefits for victims of road accidents" reflected in the PIP statute and WAC regulations. Commercial practices that

violate public policy can establish a non-per se unfair practice that violates the CPA. *See, Klem v. Wash. Mut. Bank,* 176 Wn.2d 771, 787, 295 P.3d 1179 (2013)(a *non-per se* unfair CPA practice can be shown if "the practice without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law or otherwise…").

III. DECISION BELOW FOR WHICH REVIEW IS SOUGHT

Despite acknowledging Dr. Folweiler's Complaint alleged his fees *were reasonable* given his background, experience, credentials and personal attributes and *the same amounts* other insurers paid him as "reasonable expenses" under their PIP policy, the trial court granted Am. Fam's CR 12(b)(6) motion. It ruled his Complaint failed to state an unfair CPA practice claim as a matter of law. It also denied Folweiler's motion for reconsideration despite conceding Am. Fam. admitted it paid all but $26 of Dr. Folweiler's bills as "reasonable medical expenses" after he filed a complaint with the Insurance Commissioner and it still owed him $26.[7]

On August 27, 2018, the Court of Appeals reversed holding the Complaint stated a *non-per se* unfair practice claim based on

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[7] *See,* Appellant Folweiler's Opening Brief in the Court of Appeals at 43.

violation of the public policy in the PIP statute's requirement to make "*payments* of *all* reasonable" expenses and the WAC requirement that the insurer not deny payment "without*"* first investigating if the bill is reasonable. Opinion at *7-9. The court held the statute and WAC 284-30-330 taken "together unequivocally establishes a duty to *actually investigate* and conduct a reasonable investigation of claims," before denying payment of reasonable bills and "this requires an *individualized assessment* and not simply applying a geographic based *formula* on each claim *regardless of individual circumstances*." Opinion at 10, emphasis added.

The court held "the allegations in Folweiler's complaint are sufficient to establish an unfair act in violation of the CPA based on the public interest embodied in WAC 284-30-330" and also "based on the public interest embodied in RCW 48.22.095(1)(a) and RCW 48.22.005(7)," i.e. the PIP statute. It reversed the dismissal order stating that: "Because Folweiler sufficiently pleaded the required CPA elements, the trial court erred in dismissing the case for failure to state a claim under CR12(b)(6)." Opinion at *11.

IV. ISSUE PRESENTED

The issue on Am. Fam.'s Petition is not what happens in other states or in the *heathcare* insurance market. The issue is

whether the Court of Appeals properly applied the rules governing consideration of a CR 12(b)(6) motion and correctly opined under Washington's strong public policy of *full compensation of benefits* on *PIP claims* that an *auto* insurer's practice that allows a computer to automatically deny payment of reasonable provider bills *without* investigating and determining the fee charged is unreasonable states a *non-per se* unfair CPA practice claim. On Am. Fam's 12(b)(6) motion, the trial court had to accept *as true* Dr. Folweiler's allegation his fees were reasonable for *his* services and reasonable in his high cost area for a board certified chiropractor with over 20 years of practice and special training. It had to accept *as true* Folweiler's allegation that Am. Fam's adjuster automatically denied payment based *solely* on the FH 85th percentile amount set by the computer without *first* investigating or determining his fees were unreasonable. And that the adjuster did not know how the computer set the amount, did not know what the average or "going rate" for the treatment was in Folweiler's area and made no effort to find out.

The court had to accept as true Folweiler's allegation that the FH database does not and *cannot* determine a reasonable fee for a Washington provider for *any* procedure in *any* area because it has incomplete and inaccurate charge data and does not collect

data on providers. And Folweiler's allegation that given its limited data, the FH database does not determine what rate a majority of providers in the area bill for the procedure or a majority of providers charge with similar years of practice, credentials or training.

Am. Fam. does not dispute that it restricts "*payments of all reasonable"* expenses on PIP claims to the 85th percentile amount which effectively adds an additional condition to its payment that charges must be below that amount. But *that* condition is not in WAC 284-30-395(1) as a basis for denying payment and it is inconsistent with the public policy of "*full* compensation of benefits" on PIP claims reflected in the PIP statute and WAC. It is contrary to the dictionary meaning of "all" as "*every*, all manner, all kinds."

On a 12(b)(6) motion, a court makes all inferences in the plaintiff's favor, considers hypothetical facts showing a claim for relief, does not consider defendant's assertions that dispute the plaintiff's factual allegations or matters outside the pleadings. The motion is rarely granted. In reversing the trial court's order, the Court of Appeals correctly applied these rules. Opinion at *5.

Am. Fam.'s Petition on the other hand asks this Court to accept its factual claims as true that contradict Dr. Folweiler's allegations. It asserts his fees are not reasonable, because his rate

"exceeded the 80th percentile" of the FH database for the area. Petition at 7. And, he is one of the providers "who charge high end rates." *Id.* at 8.The Complaint alleges the opposite, *i.e.*, his fees are reasonable in his high cost area of Seattle for a chiropractor with his years of practice, certification and special training and the same rates other auto insurers pay him in full as "reasonable."

Because Am. Fam. denied Folweiler's reasonable charges without investigating or determining the fees were unreasonable, the Court of Appeal's opinion is consistent with the plain language of the PIP statute, WAC 284-30-330 and WAC 284-30-395(1) and the *non-per se* unfair practice CPA claim described in *Klem, supra.*

The trial court's order dismissing the case is not. If the fees were reasonable *as alleged*, then Am. Fam. had to pay them to fulfill its affirmative duty under the PIP statute to make "*payments* of *all reasonable"* expenses. If it failed to investigate *before* denying payment, *as alleged*, then Am. Fam. failed to fulfill its affirmative duty under WAC 284-30-330 when it denied payment based *solely* on the FH 85th percentile amount *without* any investigation. If it denied payment without *first* determining Dr. Folweiler's fees were unreasonable for *him* to bill for *his* services, *as alleged,* then Am. Fam. failed to fulfill its affirmative duty under WAC 284-30-395(1).

Folweiler's allegations state a *non-per se* unfair practice CPA claim under *Klem. A*m. Fam.'s practice violates the PIP statute and WAC and violates the "strong *public policy* in favor of the *full* compensation of medical benefits for victims of road accidents" reflected in the statute and WAC. *Durant, supra.,* emphasis added.

V. STATEMENT OF THE CASE

Unlike Illinois and other states, Washington is a "no-fault" auto state. Washington citizens who want to drive must buy auto insurance. But if they have PIP coverage and are injured in an accident, they are entitled to have "*all* reasonable and necessary" treatment expenses paid by their *insurer, without regard* for who was at fault for the accident. RCW 48.22 *et seq.* The legislature enacted a broad PIP statute and the Insurance Commissioner adopted broad WAC regulations to "reflect Washington's strong public policy in favor of the full compensation of medical benefits for victims of road accidents." *Durant, supra.* at 8-9.

"At-fault" insurance states, like Illinois, do not have similar PIP statutes or regulations. Under their laws, an injured party's provider is not entitled to be paid by the insurer unless the party was not "at-fault" for the accident. Am. Fam.'s claims about what

occurs in other states are irrelevant given Washington's public policy in favor of "*full compensation of benefits"* on PIP claims.

The PIP statute imposes an *affirmative duty* on insurers to make "payments of all reasonable" expenses and not just anything the insurer wants to pay. *Durant, supra.* at 18. As the Insurance Commissioner stated in its *Amicus Curiae Brief* to this Court in *Durant*: "[C]arriers must not be allowed to use unilaterally created definitions to eviscerate the protections the Legislature and the Commissioner intended." [8] To defray the cost of providing the broad protection the Legislature and Commissioner intended, insurers are allowed to and *do* charge separate PIP premiums. According to the Commissioner's annual reports, from 2013 to 2017, Am. Fam. got $950 million in PIP premiums, only paid out $690 million on claims, and had a profit of $260 million, or nearly 38%, on PIP coverage.[9]

A. The FH Database Cannot Determine Reasonable Fees

Am. Fam.'s Petition rests on unsubstantiated and inaccurate *factual* claims about its use of the FH database which it asks this Court to accept as true. It says relying *solely* on the 85th percentile of charges to deny payment of reasonable provider bills is

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[8] *See, Amicus Curiae Brief,* **Appendix C** at 14.
[9] *See,* Chart, **Appendix D,** summarizing Annual Reports for 2013 to 2017.

consistent with Washington law because it is only denying payment to "providers who charge high-end rates." Petition at 8. And claims it pays "in full" the "average fees" for the procedure in the provider's area. *Id.* But its factual claims are not considered on a 12(b)(6) motion because they are contrary to Dr. Folweiler's allegations.

The Complaint alleges his fees are reasonable and the FH database cannot determine reasonable fees because its data is insufficient to determine what providers charge for a procedure in the city where it was provided. It alleges that FH does not collect at least one charge for the same procedure from every provider in any area, so it is impossible to determine using *only* the FH database what a majority of provider's charge in the area. CP 7. It alleges FH does not get charges from providers directly or auto insurers but only from a limited number of health insurers who then turn around and use the database to reduce payments to health care providers. CP 7. The trial court had to accept these allegations as true.

Indeed, in support of the Complaint's allegations and to show hypothetical facts that could be shown to support his claim for relief, Folweiler submitted the deposition of FH through its director of data Erik Okurowski, and its president, Robin Gelburd, that it is *impossible* to determine if a provider's bill is a reasonable charge

for the treatment based only the 85th percentile of FH database of charges because FH does *not* collect data based on providers and does *not* collect at least one charge from every provider in the area for the same procedure. *See,* Folweiler Opening Brief at 18.

Because FH does not collect at least one charge from every provider in an area that bills for the same procedure, it is impossible to say whether the 85th percentile represents what a "majority" of providers in an area charge or represents only what 30% of providers charge. The vast majority of providers could charge more. As FH said in deposition, when using only the 85th percentile of its database, it is impossible to even get a "margin of error" on how far away the 85th percentile amount is from what a majority of providers in the same area actually charge. Folweiler Opening Brief at 57.

The Complaint also alleged that the FH database was not materially different than its processor, the Ingenix database. Progressive used the 90th percentile of that database to deny payment of reasonable provider charges on Washington PIP claims. Complaint at ¶¶ 3.30-3.41. In 2010, a class of Washington providers sued Progressive over its practice of making automatic, computer denials at the 90th percentile amount. The issue of whether Progressive's practice was an unfair CPA practice that

violated the PIP statute and WAC regulations went to trial in 2012. A King County jury of 12 reached a *unanimous verdict* that Progressive's practice was an unfair CPA practice that caused injury to the provider's business on *a class-wide basis. Id*

Like Ingenix, FH only gets charges from a small number of health insurers and lumps together the charges for the same CPT procedure by broad "geo-zip" areas defined by the first 3 digits of the area's zip code. Complaint at ¶¶ 3.30-3.41. So a Seattle provider's fee for a 97124 CPT procedure is compared to the 85th percentile of charges submitted by FH health insurers from White Center, Burien, Bainbridge Island and unincorporated areas of King County because, like Seattle, they all have zip codes that start with "981." So in 2015, when Am. Fam. denied Dr. Folweiler's bills, 85% of the *lowest* charges for the 97124 procedure that FH's health insurers *chose* to submit in 2015 or prior to 2015 could have been charges from only three large chiropractic clinics in White Center and Burien, with no charges at all from Folweiler's area in Seattle.

That's because the 85th percentile amount just means that 85% of the charges that happen to be in the FH database for the CPT procedure in 2015 are *at or below* that amount, no matter what year the charges were billed in or were submitted to FH. If 85% of

the charges come from low cost areas or from only three large providers who charge low fees because they do a "volume" business or only charge health insurers a low rate, then the 85th percentile will not represent fees charged by a majority of providers in the area let alone determine "*all*" reasonable fees in the area.

Because FH does not differentiate between providers based on their years of experience or any other individual attribute, it is impossible to use the 85th percentile of the FH database to determine what a majority of *similar* providers in the area with similar years of experience, credentials or training charge for the same CPT procedure. A Seattle chiropractor, like Dr. Folweiler, with over 20 years of practice, board certification and training in the rehabilitation of patients with auto accident injuries has his fees compared to fees for the same CPT procedure billed by nurse practitioners, chiropractors in training, first year chiropractors or any other type of provider who billed one of the health insurers who sent charges into FH for the same CPT procedure. If 85% of the lowest charges come from nurse practitioners, chiropractors in training or first year chiropractors then Dr. Folweiler's rates will not be compared to any provider who has any comparison to him.

Because its charge data is limited, incomplete and does not include information on similar providers, FH expressly tells users:

> The FAIR Health products *do not* set forth a stated or an implied *reasonable and customary charge* or *allowed amount*…(and) Licensee *shall not* represent or characterize its use of the FAIR Health products *in any way* contrary to the description of how that FAIR Health product is offered by FAIR Health as expressed herein.[10]

According to FH, the database supplier, Am. Fam. cannot use its database to determine "a stated or an implied reasonable and customary charge" for Washington providers. Under the licensing contract, Am. Fam. should not represent to insureds, providers or *this Court* that in using the FH 85th percentile limitation, it is paying "average fees" in an area and only denying payment to "providers who charge high-end rates." There is absolutely no factual basis to such claims. FH says its database does not do that.

VI. REASONS WHY REVIEW SHOULD BE DENIED

While ignoring the rules applicable to appellate review of a 12(b)(6) order, Am. Fam. argues review is proper because the Court of Appeals opinion confuses insurers about "their ability to evaluate and manage healthcare costs." This case has nothing to do with *healthcare costs*, the healthcare market or insurance. It

[10] *See,* FH licensing agreement for database, CP 911-13, (emphasis added).

involves what *auto* insurers must do to comply with their *affirmative duties* to pay “all reasonable” expenses under the PIP statute and Washington’s public policy of full compensation of PIP benefits. The requirements are set out in WAC 284-30-395(1) and 284-30-330 and include affirmative duties to investigate and determine if the charge is reasonable *before* denying payment, not after. There is no statute that requires healthcare insurers pay “all reasonable” expenses. Most negotiate *in advance* with providers to take a lower rate than their market rate for inclusion in a PPO plan. The Court of Appeals Opinion is consistent with the plain language of the PIP statute, WAC regulations and the public policy stated in *Durant.*

It is also consistent with *Klem* that a plaintiff can prove a *non-per se* unfair CPA practice claim if the practice violates public policy reflected in statutes or regulations; and *Panag v. Farmers Ins. Co. of Wash.,* 166 Wn. 2d 27 (2009), that a plaintiff does not need a contractual relationship with the insurer to prove a CPA claim. The plaintiff only has to prove the insurer’s unfair practice caused injury to its business or property. *Id.* Folweiler’s Complaint alleges injury to its business caused by Am. Fam.’s failure to pay its bills and the delay in paying its bills due to 85th percentile denials.

Nor is requiring WAC compliance of Am. Fam's duty to investigate rather than using a database percentile to automatically deny payments make Washington an "outlier" state.[11] Other states require insurers to document every step taken before denial and to train adjusters to investigate. **Appendix E** ¶ 22. Consistent with *Durant,* other states do not permit carriers to use "any preestablished limitations on the benefits." *See* 2018 Minnesota Statutes, ch. 65B.44 § 1(b).

Nor does Am. Fam. cite any government approval of its practice by the state of Washington and its practice is not fair to providers or insureds. It underpays providers for services routinely paid as reasonable by other auto insurers and gives Am. Fam. a competitive advantage by lowering its costs and payouts. It forces providers to "balance bill" or send the insured to collections and subjects the insured to such risks. It elevates Am. Fam's interests above the insured's interests and shifts the burden of fulfilling its affirmative duties onto the backs of insureds and providers.

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[11] *See,* Stipulation and Consent Order in *In re United Services Automobile Association (NAIC#25941),* **Appendix E** at ¶ 27(a), wherein Vermont required USAA to cease its practice of denying payment of medical expense bills on auto claims based solely on the 80th percentile of a database of charges and to instead pay either the agreed upon "PPO" rate or "the charged amount for services that are related to injuries sustained in a the motor vehicle accident."

Nor is the Opinion reversing the 12(b)(6) order inconsistent with the rule of law *in "bad faith"* cases that an insurer's good faith denial of *coverage* based on a reasonable interpretation of law is not an unfair CPA practice. Dr. Folweiler's claim is not for violation of the good faith statute, RCW 48.010.030, but violation of the PIP statute and WAC. Am. Fam. did not deny payment for lack of coverage, but on "reasonableness," which is a separate basis from "coverage" for denying a PIP claim. WAC 284-30-395(1). Am. Fam.'s interpretation of the PIP statute as permitting *automatic* denials without investigation or determination of reasonableness is contrary to plain language of WAC 284-30-330 and 284-30-395(1) and a public policy of *full compensation* of benefits on PIP claims.[12]

The appellate court followed *Klem* to find a *non-per se* unfair practice claim. It did not substitute a *per se* claim. An *individualized* assessment of the reasonableness of a provider's fee is no different than a court's individualized assessment of the reasonableness of

[12] Am. Fam. argues that by approving *settlements* in class actions that permit the use of a database *as a tool* in paying PIP claims, Superior Court judges have ruled *on the merits* that its practice is legal. A CR 23(e) approval of settlement is not a ruling on the merits and is inadmissible to show lack of liability. ER 408. The only rulings *on the merits* hold the opposite. *See,* orders, **Appendix F** and Commissioner Verhelen's order in *Kerbs v. Safeco Ins. Co. of Ill.,* **Appendix G.** And as noted, a trial on the merits in *Progressive* found an unfair CPA practice.

an attorney's fee based on the fees of other attorneys with *similar* years of practice, specialization and reputation in the same city.[13]

Am. Fam. has not said how it is such a burden on it to investigate *before* denying payment of reasonable PIP claims, when the majority of auto insurers, including Washington's largest, State Farm, is able to process, investigate and pay reasonable provider fees *without* relying on a database of charges to make automatic computer generated denials and evade their duties under the PIP statute and WAC, as Dr. Folweiler's Complaint alleges. These insurers paid Dr. Folweiler's charges in full as "reasonable."

In reality, Am. Fam.'s disagreement is not with the Court of Appeals. Its Opinion is consistent with the plain language of the PIP statute, WAC and the public policy discussed in *Durant.* Its problem is the law in Washington, i.e. the requirements of the PIP statute and WAC, the state's strong public policy reflected in the statute and WAC of *full compensation of benefits*, and this Court's holding in *Klem* on what constitutes a *non-per se* unfair CPA claim.

VII. CONCLUSION

American Family's Petition should be denied.

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[13] *See*, *Baker v. Fireman's Fund Ins. Co.,* 5 Wn. App. 2d 604, 623 (2018)("local rates charged by attorneys with similar skills and experience") *Crest Inc. v. Costco Wholesale Corp.*, 128 Wn.App. 760 (2005) (local rates not sole factor).

DATED: December 12, 2018

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CERTIFICATE OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington that on this date I electronically filed the foregoing document with the Clerk of the Court of Appeals, Division 1, and caused service on the following counsel of record, in the manner indicated:

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DATED December 12, 2018, at Seattle, Washington.

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Leslie Boston, Paralegal

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APPENDIX A

19 Oct 15

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Theresa Bagwell
American Family Mutual Insurance Company
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Madison, WI 53783

Re: Oshuna Oma
Claim #: 00-185-078029

Dear Ms. Bagwell:

Thank you for partial payment for Ms. Oma's care in my clinic. I am requesting full payment for all services performed. The care I have provided Ms. Oma is both reasonable and necessary. My charges are reasonable. I am requesting full payment.

RCW 48.22.005 (7) states "'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..." My services billed under this claim are both reasonable and necessary.

I want to remind you that WAC 284.30.330 (4) states that "refusing to pay claims without conducting a reasonable investigation" is "defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims." If you do not conduct a reasonable investigation *before* refusing to pay my claims in full, you are in violation of Washington State law. There is no evidence of you and your firm conducting a reasonable investigation.

I expect my bills to be paid in full. I base my fees on many factors, including:

- My years of experience (more than 20).
- My status as a Diplomate of the American Board of Chiropractic Rehabilitation.
- My extensive training in treating victims of motor vehicle crashes and rehabilitation.
- My practice location in a high expense major urban center.

Thus, I think my fees are appropriate given all the factors listed above. I expect prompt and full payment of my bills. I have included printouts documenting which dates of service have not yet been paid in full.

I want to remind you that there have been legal judgments against PIP carriers who do not pay the entire charges. Perhaps you and your firm are familiar with MySpine, PS v. Allstate Insurance and MySpine, PS v. Hartford Insurance, as well as the soon to be settled case MySpine, PS vs. USAA. In all three cases, PIP carriers were ordered by the court to pay providers' bills in full in addition to costs and fines.

I am requesting that you pay my bills in full within thirty days. If you do not, I will file another complaint with the Office of Insurance Commissioner. I assume that you and your employer would like to avoid that.

I have enclosed printouts from our billing software showing the shortfall. There are two printouts, as we switched to a new software system earlier this year.

Sincerely,

David Folweiler, DC, DACRB

enclosure: billing spreadsheet

APPENDIX B

FILED
16 JUL 08 PM 1:20

KING COUNTY
SUPERIOR COURT CLERK
E-FILED
CASE NUMBER: 16-2-16112-0 SEA

**IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR KING COUNTY**

FOLWEILER CHIROPRACTIC, PS, a Washington professional services corporation, Plaintiff, v. AMERICAN FAMILY INSURANCE COMPANY, Defendant.	Cause No.: **CLASS ACTION** COMPLAINT FOR VIOLATION OF CONSUMER PROTECTION ACT RCW §§ 19.86, DEMAND FOR JURY TRIAL

Plaintiff, Folweiler Chiropractic, PS, ("Plaintiff" or "Folweiler"), individually and on behalf of all members of the Class of similarly situated Washington health care providers, alleges the following Complaint and causes of action against American Family Insurance Company ("Defendant" or "American Family"):

I. PARTIES

1.1 Folweiler Chiropractic, PS ("Folweiler") is a professional services corporation that provides chiropractic and massage therapy care in King County, Washington.

1.2 Defendant American Family Insurance Company ("American Family") is a foreign insurance company that is licensed to do business in Washington and did business in Washington and King County during the period from July 8, 2012 to July 8, 2016. American Family has sold and/or underwritten automobile insurance policies in the State of Washington that provided

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Personal Injury Protection ("PIP") coverage requiring the payment of "all reasonable and necessary" medical expenses incurred by a covered person arising from a covered accident within the meaning of the PIP statute, Chapter 48.22 RCW.

II. JURISDICTION AND VENUE

2.1 This Court has jurisdiction pursuant to RCW 2.08.010 and RCW 4.28.185.

2.2 As shown by the Explanation of Remittance forms ("EORS") attached as **Exhibit 1**, Plaintiff Folweiler billed American Family for services provided in King County to patients with PIP coverage under a American Family policy and was paid less than the amount billed by Folweiler for specific CPT procedures.

2.3 Defendant paid Folweiler less than the amount billed based on P0041 reductions. The reduction was determined according to a percentile of charges in the FAIR Health ("FH") database of providers charges within a "geo-zip" geographic area. The reduced payments were made in King County, Washington, to Folweiler.

2.4 Over the period from July 8, 2012 to July 8, 2016, American Family did substantial business within King County, Washington.

2.5 Pursuant to RCW 4.12.025, venue is proper in the King County Superior Court.

III. FACTUAL ALLEGATIONS

A. <u>Plaintiffs' Individual Factual Allegations</u>

3.1 Plaintiff re-alleges and incorporates the allegations set forth in paragraphs 1.1 through 2.5 above.

3.2 During the period from July 8, 2012 to July 8, 2016, Folweiler treated patients who had PIP coverage under an auto policy issued and/or underwritten by Defendant American Family. Examples of such occasions are shown in the American Family EORs attached as **Exhibit 1** and incorporated into this Complaint by reference.

3.3 On those occasions when Folweiler provided such care and treatment, American Family directed Folweiler to bill American Family for the treatment rather than the patient.

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1 3.4 Over the period from July 8, 2012 to July 8, 2016, American Family had a general
2 policy and practice of directing Washington providers to bill American Family rather than the
3 patient for medical expenses under the PIP coverage in the American Family policy.
4 3.5 When Folweiler billed American Family, American Family accepted Folweiler's
5 bill as a claim for payment of reasonable and necessary medical expenses under the patient's PIP
6 coverage.
7 3.6 Over the period from July 8, 2012 to July 8, 2016, American Family understood
8 that the Washington PIP statute, Chapter 48.22 RCW, required that automobile insurers offer PIP
9 coverage that provided "medical and hospital benefits" with minimum limits of $10,000.
10 3.7 American Family also understood that the term "medical and hospital benefits"
11 was defined in RCW 48.22.005(7) to mean the payment of "all reasonable and necessary" medical
12 expenses incurred by a covered person arising from a covered accident.
13 3.8 American Family also understood that the Washington PIP statute required that all
14 reasonable medical expense bills submitted by a provider under its PIP coverage be paid in full if
15 the treatment was necessary and otherwise covered by its insurance policy provisions.
16 3.9 From July 8, 2012 to July 8, 2016, American Family understood that WAC
17 §284.30.330 of the Washington Administrative Code required insurers to implement and adopt
18 reasonable practices and procedures for investigating PIP insurance claims.
19 3.10 American Family also understood that WAC §284.30.330 required insurers to
20 reasonably investigate a PIP insurance claim before refusing to pay the claim in full.
21 3.11 From July 8, 2012 to July 8, 2016, American Family had a policy and practice of
22 relying on a computer database to determine payments of all medical expense bills submitted by
23 Washington providers. The database was created by FAIR Health and utilized to compare the
24 amount billed by the provider for each CPT procedure with the amount represented by the 80th
25 percentile of charges in the FH database for the same CPT procedure in the same "geo-zip"
26

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1 geographical area. The "geo-zip" area was defined as the area with the same first 3 digits in the 5
2 digit zip code associated with the provider's billing address.
3 3.12 From July 8, 2012 to July 8, 2016, American Family's practice was to limit PIP
4 payments to no more than the 80th percentile amount in the FH database.
5 3.13 When the computer's review found that the provider's billed amount was greater
6 than the 80th percentile amount, the computer automatically limited the "Payment Amount" to the
7 80th percentile amount and would show the reason for the reduction as an explanation code
8 P0041.
9 3.14 The computer created an EOR form that set out the date of service, the CPT
10 procedure code, the "Charged Amount", the "Payment Amount", and an explanation code.
11 3.15 The EOR defined a P0041 explanation code as follows:
12
13
14
15
16

> For Dates of Service 5/31/11 and prior, the amount allowed is based on benchmark data provided by Ingenix. For Dates of Service 6/1/11 and greater, the amount allowed was reviewed using the FH (Fair Health) RV Benchmark Database. Medical Providers are asked to accept the reasonable amount as full payment for health care services and not bill the patient for additional charges. We require supporting documentation to reconsider charges for additional payment.

17 Examples of such EORs created by the computer are attached as **Exhibit 1**.
18 3.16 From July 8, 2012 to July 8, 2016, the provider's bill was paid by American Family
19 at the reduced amount set out as the "Payment Amount" in the EOR. The "Payment Amount" had
20 been set by a computer using the FH database.
21 3.17 No one in the billing department at American Family or anyone else at American
22 Family made a decision that the provider's billed amount was not a reasonable amount for that
23 provider to charge in that provider's geographic area for the CPT procedure billed before
24 American Family sent the provider a reduced payment.
25 3.18 From July 8, 2012 to July 8, 2016, the American Family claims representative or
26 adjustor assigned to the PIP claim did not make a decision that the provider's billed amount was

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an unreasonable amount for that provider to charge in that provider's geographic area for the CPT procedure billed before American Family sent the provider a reduced payment that was based on the alleged prevailing billing practices.

3.19 The claims representative or adjustor did not know how the computer determined the "Payment Amount" or amount allowed on the EOR.

3.20 The claims representative or adjustor did not know the identity, background, credentials, experience, or any other personal characteristic of the individual providers in the area whose bills the computer used as comparators in arriving at the 80th percentile amount.

3.21 No one at American Family associated with the payment of the provider's bill knew the identity, background, credentials, experience or any other personal characteristic of the individual providers in the area whose bills the computer used as comparators in arriving at the 80th percentile amount.

3.22 From July 8, 2012 to July 8, 2016, the American Family representative or adjustor assigned to the PIP claim did not independently investigate whether the amount billed was a reasonable amount for that provider to charge for that CPT procedure in that provider's city. Nor did the representative or adjustor investigate if the amount billed was a reasonable amount to bill for the specific area that had the same five digit zip code as the address where the treatment had actually been provided.

3.23 No one at American Family associated with the payment of the provider's bill independently investigated whether the amount billed was a reasonable amount for that provider to charge for that CPT procedure in that provider's city. Nor did anyone associated with the payment of the bill investigate if the amount billed was a reasonable amount to bill for the specfiic area that had the same five digit zip code as the address where the treatment had actually been provided.

3.24 The claims representative or adjustor did not know whether the amount billed was a reasonable amount for that provider to charge based on the provider's background, credentials,

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usual and customary fee, the amount paid by other auto insurers, the provider's overhead costs, or any other individualized characteristic or factor relating to that particular provider.

3.25 No one at American Family associated with the payment of the provider's bill knew whether the amount billed was a reasonable amount for that provider to charge based on the provider's background, credentials, usual and customary fee, the amount paid by other auto insurers, the provider's overhead costs, or any other individualized characteristic or factor relating to that particular provider.

3.26 From July 8, 2012 to July 8, 2016, American Family knew that the amounts that exceeded the 80th percentile amount in the FH database could be a reasonable amount for the provider to charge for the CPT procedure billed.

3.27 From July 8, 2012 to July 8, 2016, the amounts Folweiler billed American Family that were reduced based on the alleged prevailing billing practices were reasonable.

3.28 The amount billed by Folweiler and reduced by American Family were Folweiler's usual and customary amounts billed to automobile insurers for the CPT procedure billed.

3.29 The amounts billed by Folweiler were paid by other automobile insurers that did not use the 80th percentile amount in the FH database to determine the amount to be paid.

3.30 In 2010, a Washington provider, Dr. David Kerbs, filed a class action against Progressive in King County Superior Court for the State of Washington. In the complaint, Dr. Kerbs alleged in words and/or substance that Progressive had a practice of reducing provider payments on PIP claims based on the 90th percentile of the Ingenix MDR database. This type of reduction is identified in the Complaint as an explanation code 41 reduction. Dr. Kerbs alleged in words and/or substance that the "amount allowed"on the EOR and paid by Progressive based on a code 41 explanation was due to a computer setting the amount at the 90th percentile amount in the Ingenix database for the same CPT procedure in the provider's geographic area.

3.31 In his complaint, Dr. Kerbs alleged in words and/or in substance that Progressive's practice of making code 41 reductions to provider bills on PIP claims violated the Washington PIP

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1 statute, the WAC insurance regulations pertaining to unfair claims handling practices, and was an
2 unfair business practice that violated the Washington Consumer Protection Act ("CPA").
3 3.32 On January 12, 2012, the King County Superior Court certified Dr. Kerbs's CPA
4 claim on behalf of a litigation class of all Washington providers who were paid less than the
5 amount billed by Progressive from August 26, 2010 to August 1, 2011 due to a code 41 reduction
6 that was based on Progressive's use of the 90th percentile of the Ingenix to set the amount allowed
7 and paid. Folweiler was a member of the Kerbs class.
8 3.33 In August 2012, the liability phase of Dr. Kerbs's class action was tried before a
9 King County jury of 12 jurors. The jury found that Progressive's practice of making code 41
10 reductions based on the 90th percentile of the Ingenix MDR database was an unfair business
11 practice that violated the Consumer Protection Act and caused injury to the provider's business.
12 3.34 On September 21, 2012, the King County Superior Court entered a judgment on
13 liability pursuant to the jury's Special Verdict. A copy of the judgment is attached as **Exhibit 2**
14 and incorporated to this Complaint by reference.
15 3.35 The FH database that American Family used from July 8, 2012 to November 23,
16 2015 in paying PIP claims in Washington relied on data collection methods that were similar to
17 the data collection methodes used by Ingenix to create the Ingenix database.
18 3.36 One similar method was that both the Ingenix and FH dataases had data that was
19 collected from specific health care insurers that then used their databases pay insurance claims.
20 3.37 Another similar data collection method was that both the Ingeix and FH databases
21 did not contain any data that was collected from Washington providers directly. Another
22 similarity was that niether the Ingenix nor FH databases had at least one bill charge from every
23 provider in the same geographic area that billed an auto insurer for the same CPT procedure.
24 3.38 Another similar data collection method was that both the Ingenix and FH databases
25 did not contain any data that was collected from Washington auto insurers.
26

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1 3.39 The FH database that American Family used from July 8, 2012 to July 8, 2016, in
2 paying Washington PIP claims relied on methodologies that were similar to the Ingenix MDR
3 database.
4 3.40 One such similar methodology was to use "geo-zip" geographical areas that were
5 based on the first three digits of the zip code associated with the provider's billing address. Both
6 FH and Ingenix used the same three-digit "geo-zip" areas for the state of Washington.
7 3.41 Some of the same flaws with with the Ingenix database identified by Dr. Bernard
8 Siskin and/or the federal court in McCoy v. Health Net, Inc., 569 F.Supp.2d 448 (D.N.J. 2008)
9 were flaws with the FH database that American Family used from July 8, 2012 to July 8, 2016.
10 3.42 Prior to July 8, 2012, American Family had no analysis or expert opinion that the
11 Ingenix database and the FH database it used were materially different in any way with regard to
12 American Family's use of these databases to pay Washington provider bills on PIP claims.
13 3.43 Prior to July 8, 2012, American Family did not determine that using a percentile of
14 the FH database would produce a materially different result with regard to the payment of all
15 reasonable medical bills submitted on Washington PIP claims than what the result would have
16 been had American Family used the Ingenix MDR database.
17 3.44 Prior to July 8, 2012, American Family did not investigate whether its use of a
18 percentile of the FH database to make prevailing billing practices reductions had resulted in the
19 same type of unfair CPA practice that the King County Superior Court jury in the Kerbs's case
20 found was an unfair CPA practice when Progressive used a percentile of the Ingenix database of
21 provider charges to make code 41 reductions to Washington provider bills.
22 3.45 Prior to July 8, 2012, American Family had no facts showing that its practice of
23 using a percentile of the FH database to make prevailing billing practices reductions to
24 Washington provider bills was materially different than Progressive's practice of using a
25 percentile of the Ingenix database to make code 41 reductions.
26

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3.46 Prior to July 8, 2012, American Family had no analysis or expert opinion that its practice of using a percentile of the FH database to make P0041 reductions to Washington provider bills was materially different than Progressive's practice of using a percentile of the Ingenix database to make code 41 reductions.

3.47 During the period from July 8, 2012 to July 8, 2016, Folweiler suffered injury and damage to its business as a direct and proximate result of American Family's practice of making P0041 reductions to Washington provider bills in the manner described above.

B. Putative Class Allegations

3.48 The Putative Class incorporates herein by reference each and every allegation contained in paragraphs 1.1 to 3.47 above as if fully set forth here.

1. American Family's Practices With Regard to the Members of the Putative Class

3.49 Over the period from July 8, 2012 to July 8, 2016, there were Washington health care providers who billed American Family for medical expenses incurred by patients with PIP coverage under a American Family policy and were paid less than the amount billed based solely on P0041 explanation code.

3.50 American Family directed these providers to bill American Family directly for the treatment under the applicable PIP policy rather than billing the patient.

3.51 These providers billed American Family their usual and customary charge for the CPT procedure that that the providers billed other auto insurers.

3.52 These providers were paid the amounts billed American Family for the CPT procedures by other auto insurers that did not use a percentile of a database to limit their payment under their PIP coverage to Washington providers.

3.53 This group of Washington providers who billed American Family over the period from July 8, 2012 to July 8, 2016 and were paid less than the amount billed due to a P0041 reduction. The providers were paid less than the amount billed based on American Family's

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practice of limiting the "Payment Amount" or amount allowed to no more than the 80th percentile of the FH database as automatically determined by a computer.

3.54 The group of Washington providers who billed American Family over the period from July 8, 2012 to July 8, 2016 and were paid less than the amount billed due to a P0041 reduction is a class of at least 900 Washington providers ("the Class members").

3.55 American Family applied the same practices described in paragraphs 3.3 to 3.53 above to these Class members that American Family applied to the bills of Folweiler.

3.56 American Family applied the same practice of using a computer to set the "Payment Amount" or amount allowed and paid at no more than the 80th percentile of the FH database to the bills of all Class members who had P0041 reductions.

3.57 The EORs that American Family sent to the Class members show occasions when American Family reduced the provider's bill based on a P0041 reduction.

3.58 The 900 members of the Class described in paragraphs 3.49 – 3.56 above are dispersed geographically over the State of Washington in multiple cities and counties.

3.59 Plaintiff Folweiler is a member of this class of Washington providers.

3.60 Prior to paying the members of this class of Washington providers less than the full amount billed based on a P0041 reduction, American Family had not entered into a contract with the provider to accept less than the provider's usual and customary charge for the services billed other auto insurers. American Family had not entered into any contract with the provider to accept less than the market rate for the services provided, defined as the amount a willing patient would pay on the open market for the services. Nor did American Family offer to pay the provider in cash, in full, at the time of service.

3.61 Over the period from July 8, 2012 to July 8, 2016, American Family did not have a practice of offering to pay providers a reduced "cash rate" at time of service.

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1 3.62 American Family knows of no occasion when American Family paid a provider in
2 cash, in full, at the time of service instead of requiring that the provider bill American Family for
3 the service.

4 3.63 American Family knows of no occasion when American Family paid a provider
5 without requiring the provider to bill American Family by CPT numbered procedures and by the
6 number of units of that CPT numbered procedure to be paid.

7 3.64 When American Family paid the Class member less than the full amount billed
8 based on a P0041 reduction, the amount paid was not based on a PPO or insurance plan rate.

9 3.65 The amount paid was not based on a fee schedule set by the State of Washington.

10 3.66 The State of Washington has not adopted a fee schedule that sets the fee to be paid
11 providers for CPT procedures billed on a PIP claims. Other states, like New Jersey, have adopted
12 such a fee schedule.

13 3.67 When American Family paid the Class member from July 8, 2012 to July 8, 2016
14 less than the full amount billed based on a P0041 reduction, the American Family claims
15 representative or adjustor assigned to the claim did not independently investigate whether the
16 amount billed was a reasonable amount for the provider to charge for the CPT procedure based on
17 that provider's background, credentials, years of practice, overhead costs, reputation, the medical
18 market in which the provider competed with other providers that provided the same treatment
19 services, the amount paid by other auto insurers, or any other individual circumstance relating to
20 the provider.

21 3.68 Before American Family sent the reduced check or payment to the Class member
22 that was based on a P0041 reduction, no one at American Family made such an investigation.

23 3.69 In paying Class members over the period from July 8, 2012 to July 8, 2016, the
24 person who made the payment for American Family relied solely on a "Payment Amount" set out
25 in the EOR as the amount to pay the provider for the CPT procedure billed.

26

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3.70 The Class members suffered injury to their businesses and/or property as a direct and proximate result of American Family's practice of making P0041 reductions from July 8, 2012 to July 8, 2016.

3.71 The total amount of prevailing billing practices reductions made to the bills of each individual Class member from July 8, 2012 to July 8, 2016 was small and averaged less than $300.

3.72 The total amount of all P0041 reductions on all bills of all members of the Class from July 8, 2012 to July 8, 2016 total less than $1 million.

3.73 The total amount in controversy on the claims of the members of the Class described in this Complaint is substantially less than Five Million Dollars ($5,000,000). The maximum amount of all damages, treble or exemplary damages, costs and attorneys fees, and/or any other relief awardable under Washington law is less than Five Million Dollars ($5,000,000).

3.74 Many of the Class members whose bills were reduced by American Family based on P0041 reductions were class members in the Kerbs case and had their bills reduced by Progressive using a code 41 reduction that was also based on a percentile of a database of charges. These providers billed American Family the same amounts for the same CPT procedure that the jury and Judge Armstrong found were reasonable amounts in the Kerbs case when billed to Progressive. Folweiler was one such Kerbs class member.

C. Civil of Procedure Rule 23 Allegations

3.75 Folweiler brings this action as a Class Action pursuant to Civil Rule 23 of the Washington State Superior Court Civil Rules. Plaintiff seeks to certify the following Class:

> All Washington health care providers who from July 8, 2012 to July 8, 2016 (the "Class period") had their PIP claims for reimbursement of medical expenses reduced by Defendant American Family Insurance Company ("American Family") based solely on an explanation code P0041 as set out in the Explanation of Remittance form sent to the provider.

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1 3.76 **CR 23(a)(1):** Class certification is proper under CR 23(a) (1) because the members
2 of the class total at least 900 health care providers and the providers are geographically dispersed
3 over numerous cities and counties in the state of Washington.
4 3.77 Because of the number of Class members and their geographic dispersion,
5 individual joinder of each putative class member is not practicable.
6 3.78 **CR 23(a)(2):** Class certification is proper under CR 23(a)(2) because American
7 Family applied a common practice of making P0041 reductions to the bills of all class members
8 over the class period from July 8, 2012 to July 8, 2016. American Family's practices raise
9 questions of law and fact common to all members of the Class including::
10 a. Whether over the Class period, the P0041 reductions made to class member bills
11 were based on American Family's use of the 80th percentile of the FH database to limit payments
12 on PIP claims.
13 b. Whether over the Class period, American Family's P0041 reductions were based
14 on a computer automatically setting the "Payment Amount" that was shown on the EOR that
15 went to providers based on the 80th percentile of the FH database.
16 c. Whether over the Class period, American Family used or relied on a percentile of
17 the FH database to make P0041 reductions without conducting its own independent investigation
18 of whether the amount billed was a reasonable amount for that provider to charge.
19 d. Whether over the Class period, American Family had knowledge of any flaws with
20 the FH database or limitations in using a percentile of the database to set or determine provider
21 payments under its PIP coverage.
22 e. Whether over the Class period, American Family had any knowledge of any
23 similarities between the Ingenix database and the FH database it used over the Class period.
24 f. Whether American Family's practice over the Class period of making P0041
25 reductions violated the requirement in the PIP statute, RCW 48.22.005(7), to pay "all reasonable"
26 medical expenses submitted.

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g. Whether American Family's practice over the Class period of making P0041 reductions violated WAC §284.30.330 et seq. that required American Family to adopt and implement reasonable procedures for investigating PIP insurance claims before refusing to pay them in full.

h. Whether American Family's practice over the Class period of making P0041 reductions violated WAC §284.30.330 et seq. that required American Family to independently investigate a PIP insurance claim before refusing to pay it in full.

i. Whether American Family's practice of making P0041 reductions over the Class period was an unfair business practice that violated the Washington Consumer Protection Act, RCW 19.86 et seq.

j. Whether there were any benefits to providers from American Family's practice of making P0041 reductions, whether the benefits substantially outweighed any detriments to the providers, and whether providers could avoid having their bills reduced based on P0041 reductions when submitting PIP claims to American Family for payment of reasonable medical expenses incurred by a covered patient.

k. Whether American Family's practice is an unfair practice that violates the CPA in relationship to the applicable Washington law and regulations relating to the payment of PIP insurance claims, including RCW 4.22.005(7) and WAC §284.30.330 et seq.

l. Whether class members sustained injury to their business caused by American Family's practice in the form of reduced payments, delay in payment of reasonable medical expenses, out of pocket administrative costs or added expenses, business interruption or inconvenience, or in some other manner.

m. Whether class members sustained monetary damages to their business caused by American Family's practice.

3.79 **CR 23(a)(3):** Class certification is proper under CR 23(a)(3) because Folweiler's claims are typical of the claims of the members of the putative class and American Family's

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1 defenses to the claims of Folweiler are also typical of the defenses to such claims. The claims and
2 defenses are typical because they arise out of the same common policies and practices which
3 Progressive applied to all Class member bills submitted under its PIP coverage. The claims arise
4 from the same alleged unfair scheme undertaken by American Family to deprive Washington
5 providers of full compensation for their services based on P0041 reductions.

6 3.80 **CR 23(a)(4):** Class certification is proper under CR 23(a)(4) because Folweiler can
7 fairly and adequately represent the interests of the other members of the Class. He has no interests
8 that are antagonistic to the interests of the Class members in seeking full payment of all bills
9 reduced using P0041 reductions. Folweiler has retained skilled attorneys who have represented
10 claimants and class members with similar claims to those brought in this lawsuit. Folweiler's
11 counsel were appointed Class counsel in the Kerbs case discussed in paragraph 3.30 above.

12 3.81 **CR 23(b)(3):** Class certification is proper under CR 23(b)(3) because the questions
13 of law and fact common to the class, as set forth above in paragraph 3.64 predominate over any
14 questions affecting only individual members of the class. Common questions predominate
15 because American Family undertook a common course of conduct towards all members of the
16 class of Washington health care providers and applied its practices at issue to all bills submitted
17 under its PIP coverage during the class period.

18 3.82 Class certification is proper under CR 23(b)(3) because a class action is a superior
19 method for adjudicating the claims of the members of the class than hundreds of individual
20 actions in numerous cities and counties of Washington that raise the identical factual and legal
21 issues concerning American Family's reimbursement practices based on prevailing billing
22 practices reductions.

23 3.83 Class certification is a superior method of adjudicating the claims because the
24 individual class members have little interest in individually controlling the prosecution of their
25 claims. The average amount of the individual claims in controversy is likely to be less than $300.
26

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3.84 The class members are busy health care professionals who have limited time to devote to the prosecution of their individual claims.

3.85 Class certification is a superior method of adjudicating the claims because there is no significant individual litigation already commenced by Washington health care providers against American Family raising the identical claims relating to the FAIR Health database.

3.86 Class certification is a superior method of adjudicating the claims because it is desirable to concentrate the litigation and claims in a single forum to avoid duplicity of actions and inconsistent adjudications of identical claims. King County is a desirable forum for litigation of the class claims because it is the County in which most class members are located and where the Defendants' in-state witnesses are likely located. The cost to the court system of the various counties where class members are located would be substantial if the claims were adjudicated on an individualized basis.

3.87 Class certification is a superior method of adjudicating the claims because there are few difficulties likely to be encountered in the adjudication of the class members' legal claims. The King County Superior Court certified a litigation class that alleged similar claims in the Kerbs case. The common liability issues were tried to a jury on a class basis and a verdict entered.

IV. LEGAL CLAIMS AND CAUSES OF ACTION

COUNT I: VIOLATION OF CONSUMER PROTECTION ACT

4.1 Plaintiffs re-allege each and every allegation as set forth in paragraphs 1.1 to 3.87 above as through set forth here.

4.2 American Family's practice over the class period of making P0041 reductions violated the requirement in the PIP statute, RCW 48.22.005(7), to pay "all reasonable" medical expenses submitted.

4.3 American Family's practice over the class period of making P0041 reductions violated WAC §284.30.330 et seq. that required American Family to adopt and implement reasonable procedures for investigating PIP insurance claims before refusing to pay them in full.

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4.4 American Family's practice over the class period of making P0041 reductions violated WAC §284.30.330 et seq. that required American Family to independently investigate a PIP insurance claim before refusing to pay it in full.

4.5 American Family's practice of making P0041 reductions occurred in the course of its business and in commerce.

4.6 American Family's practice in making P0041 reductions was part of a generalized course of conduct repeated on thousands of occasions when provider bills were submitted to American Family for payment under its PIP coverage over the class period.

4.7 American Family's practice affected the public interest.

4.8 The business of insurance affects the public interest. RCW48.01.030.

4.9 American Family's practice of making P0041 reductions occurred in the course of its insurance business and affected at least 900 Washington health care providers or more over the Class period.

4.10 American Family's practice of making P0041 reductions over the class period was an unfair practice that violated the Washington Consumer Protection Act, RCW 19.86 et seq.

4.11 There were no benefits to providers from American Family's practice of making P0041 reductions. Any benefit to providers of American Family's practice was substantially outweighed by the detriments to the providers in having their bills reduced. Providers could not avoid having their bills reviewed and reduced based on P0041 reductions when submitting PIP claims to American Family for payment of reasonable medical expenses incurred by a covered patient.

4.12 American Family's practice of making P0041 reductions over the class period was an unfair business practice that violated the Washington Consumer Protection Act, RCW 19.86 et seq., in relationship to the requirements of the PIP statute and WAC §284.30.330 et seq.

4.13 Class members sustained injury to their business caused by American Family's practice in the form of reduced payments, delay in payment of reasonable medical expenses, out of pocket administrative costs or added expenses, business interruption or inconvenience.

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4.14 Class members sustained damages that were proximately caused as a direct result of American Family's practice.

4.15 American Family is liable to Plaintiff and the Class for statutory, actual and treble damages, prejudgment interest, attorneys' fees and costs under the CPA, RCW 19.86 et seq.

V. DAMAGES

Plaintiff and the Class incorporate the allegations made in paragraphs 1.1 – 4.15 above as though fully set forth herein.

5.1 As a direct and proximate result of American Family's wrongful conduct described in paragraphs 1.1 – 4.15 above, the Plaintiff and the Class sustained injury to their property and business and damages in amount that will be established at trial, but which amount is substantially less than $5,000,000.

5.2 The injury and damages include but is not limited to loss of income from under-payment of their bills, delayed payment of their bills, loss of revenue due to time spent away from their health care practice to address American Family's wrongful conduct and out of pocket expenses. Excluded from damages are P0041 reductions that were subsequently paid in full by American Family and reduction made on PIP claims with exhausted policy limits.

5.3 Folweiler's individual claim is less than $50,000.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs and the Class respectfully pray that this Court enter judgment in their favor and against Defendant American Family on their Consumer Protection Act claim and that the Court:

6.1 Certify the case as a Class Action under CR 23 on behalf of the alleged Class.

6.2 Award actual damages to be established at trial as provided by the Consumer Protection Act (CPA), RCW 19.86 et seq.;

6.3 Award treble damages as provided by the CPA, RCW 19.86 et seq.;

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1 6.4 Award Plaintiff a reasonable class representative fee in an amount approved by the
2 Court and award reasonable attorney's fees and costs as provided by the CPA and class action law
3 in amounts approved by the Court;
4 6.5 Award plaintiffs and the Class prejudgment interest at the rate of 12% per annum as
5 provided by the CPA, RCW 19.86 et seq. or such other rate provided by law; and
6 6.6 Award plaintiffs and the Class, their reasonable litigation expenses, disbursements
7 and costs of suit.
8 Dated July 8, 2016:
9 BRESKIN JOHNSON & TOWNSEND, PLLC
10 By: *s/ David E. Breskin*
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APPENDIX C

FILED
SUPREME COURT
STATE OF WASHINGTON
1/25/2018 9:20 AM
BY SUSAN L. CARLSON
CLERK

FILED
FEB 20 2018
WASHINGTON STATE
SUPREME COURT

NO. 94771-6

SUPREME COURT OF THE STATE OF WASHINGTON

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

Plaintiffs

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant.

AMICUS CURIAE BRIEF

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ORIGINAL

filed via
PORTAL

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I. INTRODUCTION

The Legislature has broadly defined the medical and hospital benefits covered under personal injury protection (PIP) insurance as "all reasonable and necessary expenses incurred by or on behalf of the insured..." RCW 48.22.005(7). In keeping with this broad scope of coverage, the Insurance Commissioner promulgated rules clarifying that the coverage for medical and hospital benefits is broad, and that the bases for denial of medical and hospital benefits under PIP are narrow and limited. In particular, WAC 284-30-395(1) establishes the only grounds carriers are permitted to use for denying, limiting, or terminating medical and hospital coverage provided as part of PIP insurance. The Commissioner, through his staff, have clearly communicated to State Farm that the use of "maximum medical improvement" as an additional basis for the denial of claims is contrary to WAC 284-30-395(1). Moreover, it is the Commissioner's position that WAC 284-30-395(1) should not be used to allow carriers exclude otherwise necessary and reasonable medical and hospital services by inserting additional coverage restrictions into their contract definitions of the terms "reasonable" and "necessary". Allowing such an interpretation would open the door for carriers to exclude nearly all services. Such an

interpretation would make the $10,000 statutorily mandated medical and hospital benefits required under PIP largely illusory.

II. IDENTITY AND INTEREST OF AMICUS

Mike Kreidler, Insurance Commissioner for the state of Washington ("Commissioner"), is the head of the Office of the Insurance Commissioner ("OIC"). He is charged with regulating insurance in this state and enforcing the provisions of the Insurance Code, RCW Title 48, and administrative regulations adopted thereunder, found in WAC Title 284. This includes the enforcement of rules defining unfair or deceptive trade practices in the context of personal injury protection (PIP) insurance. As such, the Commissioner has an interest in ensuring that rules promulgated under the Insurance Code are interpreted in a manner that is reasonable and consistent with the Commissioner's intent, and that provides protection for consumers and fosters a robust insurance market.

III. SCOPE OF AMICUS BRIEF

This brief will address the intent and legislative history of WAC 284-30-395 and will provide the Commissioner's interpretation of this rule as a limit on a carrier's ability to refuse payments for injuries under personal injury protection (PIP) insurance on grounds that are not enumerated in the rule. This brief will also clarify the communications the

Commissioner and the OIC have had with State Farm concerning the interpretation of WAC 284-30-395.

IV. ISSUES

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

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)?

V. FACTS RELEVANT TO AMICUS

The Legislature has granted the Commissioner the authority to "define other methods of competition and other acts and practices in the conduct of such business reasonably found by the Commissioner to be unfair or deceptive." RCW 48.30.010(2). In 1978, the Commissioner promulgated rules setting minimum standards for claims settlement practices. WAC 284-30-300. These regulations apply to "all insurers and to all insurance policies and insurance contracts." WAC 284-30-310.

In 1993, the Legislature established requirements for personal injury protection (PIP) insurance. Laws of 1993, ch. 242. Among other things, all carriers offering automobile liability insurance are also required to offer optional PIP coverage whenever they offer automobile liability insurance.

Laws of 1993, ch. 242, §§ 2, 4 (codified at RCW 48.22.085 & RCW 48.22.095). As part of PIP coverage, carriers are required to offer no less than $10,000 in coverage for medical and hospital benefits. RCW 48.22.095(1)(a). "Medical and hospital benefits" are defined in part 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). Notwithstanding these requirements, from 1991 to 1996, the Commissioner received approximately 700 complaints concerning the way insurers deny, limit, and terminate PIP benefits. Concise Explanatory Statement (CES) at 1, attached hereto as Appendix A.[1]

In 1996, the Commissioner initiated rulemaking under RCW 48.30.010(2) to address company practices concerning PIP benefits. Among other things, those rules clarified that the only permitted bases for denying, limiting, or terminating medical and hospital benefits under PIP is

[1] Under the current APA, before an agency files an adopted rule with the Code Reviser, it must prepare a concise explanatory statement: (i) Identifying the agency's reasons for adopting the rule; (ii) Describing differences between the text of the proposed rule as published in the register and the text of the rule as adopted, other than editing changes, stating the reasons for differences; and (iii) Summarizing all comments received regarding the proposed rule, and responding to the comments by category or subject matter, indicating how the final rule reflects agency consideration of the comments, or why it fails to do so. RCW 34.05.325(6)(a). This record must be made available to the public upon request. As such, this CES is public record of which this Court may take judicial notice.

that the services are not reasonable, necessary, related to the accident, or incurred within 3 years of the accident. WAC 284-30-395(1).

In May 2015, counsel for the Plaintiffs contacted the OIC, specifically staff in the OIC Rates and Forms Division, alleging that State Farm was using the term "maximum medical improvement" as a limitation on the medical and hospital services benefits it was paying under PIP coverage. Dkt. 61, p. 2. The language concerning "maximum medical improvement" was originally approved by OIC staff in 1994, prior to the implementation WAC 284-30-395. Dkt. 7-7, p. 56. This policy language remained unchanged when OIC staff approved an updated policy form in 2006. Dkt. 39-1, p. 24. However, the 2006 filing, did not change the language of "maximum medical improvement" as a change. Dkt. 39-1. Nor did it request that the OIC specifically review that language. Id. Moreover, none of the correspondence presented by State Farm concerning the OIC's review of the 2006 filing identifies review of the "maximum medical improvement" improvement language. Defendants Response Brief (Resp. Br.), Exhibit 4.

Notwithstanding the prior approvals, upon receiving the complaint, the Commissioner, through his staff, promptly contacted State Farm and informed them that the use of "maximum medical improvement" as an additional limiting factor for payment of PIP claims was inconsistent with

WAC 284-30-395. Letter from Alan Hudina to State Farm Insurance, dated July 23, 2015 at 1, attached hereto as Appendix B[2]; *see also* Resp. Br. at 17, and Dkt. 70, p. 8. The Commissioner, pursuant to RCW 48.18.510, directed State Farm to administer their policy consistent with WAC 284-30-395, and to refile their policy form without the language that seemed to add "maximum medical improvement" as a limit on medical and hospital services, contrary to WAC 284-30-395. Appendix B at 2. This is the only substantive correspondence the Commissioner or his staff have had with State Farm concerning the Commissioner's interpretation of WAC 284-30-395.[3]

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[2] Defendants have asked this Court to take judicial notice of several records produced by the Commissioner in response to Plaintiff's public records request. Resp. Br. at 13, ft. 4. If the Court is inclined to take judicial notice of those records, the Commissioner asks that the Court also take judicial notice of the letter produced in response to the same public records request, found at Appendix B. Alternatively, the Commissioner asks this Court to consider this letter pursuant to RAP 9.11. This letter is necessary to fairly resolve the question of what the Commissioner's staff have communicated to State Farm concerning his interpretation of WAC 284-30-395(1). Although State Farm has referred to this letter in their briefing, it has not included this letter in the record. (*see* Resp. Br. at 17, and Dkt. 70, p. 8). Consideration of this letter has the potential to alter what the Court understands the Commissioner's stated interpretation of this rule has been, an interpretation that may be entitled to deference. As the Commissioner was not a party to the proceedings below, he had no mechanism for submitting this record to the District Court. As amicus curiae, the Commissioner has no post trial or other appellate remedies. Finally, it would be inequitable to determine the Commissioner's interpretation of WAC 284-30-395(1) without considering the primary communication the Commissioner, through his staff, has had with State Farm concerning WAC 284-30-395(1).

[3] The Commissioner, through his staff, have corresponded with State Farm concerning this litigation, and much of that correspondence has been included in the record. However, there has not been any further statement or representation made by the Commissioner to State Farm offering a different interpretation of WAC 284-30-395.

This letter was consistent with the Commissioner's rejection of the use of similar language in a policy issued by American Family Insurance, in 2010. Dkt. 73, pp. 20-21. The Commissioner rejected American Family Insurance language ending payments when "recovery has reached a plateau, or improvement in the bodily injury has slowed or ceased entirely." *Id.* at 20. Like the State Farm policy, the American Family Insurance policy had been approved by OIC staff. *Id.* Even so, American Family was directed, pursuant to RCW 48.18.510, to administer its plan consistent with WAC 284-30-395(1), and to submit new language consistent with the rule. *Id.* at 21.

In addition to directing State Farm to resubmit its policy forms, the letter referred the matter to the Commissioner's market conduct staff. Appendix B, p. 2. Market conduct actions, such as market continuum reviews and market conduct exams, are designed to identify and asses practices in the insurance market place that have an adverse impact on consumers, policyholders, and claimants. RCW 48.37.010. As part of a market conduct action, the Commissioner and his staff have the authority to demand virtually any documents, data, or information in a carrier's possession related to that market conduct action. For this reason, market conduct actions are entirely confidential. RCW 48.37.080. In this instance, when market conduct staff concluded their work, the matter was referred to

the OIC Legal Division to determine what, if any, additional steps were necessary. On September 29, 2016, an OIC Legal Division staff member drafted a legal opinion concerning whether State Farm's contract language violates WAC 284-30-395(1). Dkt. 74-1, pp. 2-3. The internal memorandum concluded that there was no conflict because it was consistent with regulations issued by the Department of Labor and Industries (L&I). *Id.* at 3. However, the memorandum did not cite, let alone analyze, any particular L&I rule or statute. *Id.* Nor did it discuss the propriety of applying one L&I definition in the PIP context. *Id.* This internal opinion was not adopted or published by the OIC as guidance. In fact, staff from the OIC Rates and Forms Division requested that the opinion be reconsidered. Dkt. 74-1, p. 5. This internal opinion was not shared with State Farm at that time. At no point in time has the Commissioner or his staff indicated to State Farm that they have adopted a different definition of WAC 284-30-395 than the interpretation articulated in the letters to American Family Insurance, and to State Farm itself.

VI. ARGUMENT

As a general matter, substantial weight is accorded to an agency's interpretation of statutes that the agency administers. *PUD 1 of Pend Oreille Cy. v. Dep't of Ecology*, 146 Wn.2d 778, 790, 51 P.3d 744 (2002); *King Cy. v. Central Puget Sound Growth Mgmt. Hearings Bd.*, 142 Wn.2d

543, 553, 14 P.3d 133 (2000). This is especially true when the agency has expertise in a certain subject area. *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 593-94, 90 P.3d 659 (2004); *Inland Empire Distrib. Sys., Inc. v. Utils. & Transp. Comm'n*, 112 Wn.2d 278, 770 P.2d 624 (1989). Thus, "[a]lthough a commissioner cannot bind the courts, the court appropriately defers to a commissioner's interpretation of insurance statutes and rules." *Credit Gen. Ins. Co. v. Zewdu*, 82 Wn. App. 620, 627, 919 P.2d 93 (1996). The plain language of WAC 284-30-395 clearly prohibits the use of "maximum medical improvement" as an additional grounds for the denial, limitation, or termination of PIP benefits aside from those listed in WAC 284-30-395(1). However, because WAC 284-30-395 does not define the terms "reasonable" or "necessary," it is possible that a carrier could use terms like "maximum medical improvement" to help policy holders understand what "reasonable" and "necessary" services are. But a carrier cannot, under the pretense of providing a definition of "reasonable" or "necessary," effectively create an additional grounds for denial, limitation, or termination of PIP benefits, as this would be inconsistent with WAC 284-30-395(1).

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A. The Commissioner, Through His Staff, Has Clearly Communicated To Carriers That WAC 284-30-395(1) Does Not Permit Additional Grounds For Denial, Limitation, Or Termination Of PIP Benefits

In defining medical and hospital benefits, the Legislature clearly intended that medical and hospital benefits be broadly available under PIP coverage. To that end, RCW 48.22.005(7) provides:

> "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.

Nowhere does the statute exclude palliative care, or care to maintain a stable condition, rather than to improve a person's condition. Rather, the Legislature chose the phrase "all reasonable and necessary" as the parameters for determining care that must be covered.

In keeping with the inclusive language of RCW 48.22.005(7), the rules promulgated by the Commissioner to address the handling of medical and hospital benefits in PIP coverage provide, in part:

> (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). Although the terms "reasonable" and "necessary" are not defined in the rule, there is no question that a carrier cannot structure their policy in such a way that they are entitled to assert an additional basis for denying, limiting, or terminating payment of medical and hospital services. A carrier cannot enforce a policy that denies medical and hospital services that are reasonable, necessary, related to the accident, and incurred within three years of the accident, but that do not achieve 'maximum medical improvement.

This interpretation of WAC 284-30-395 has been clearly communicated by the Commissioner, through his staff, to American Family Insurance in 2010, and again to State Farm in 2015, when taking exception to the language in their policies. In both instances, the Commissioner has

directed carriers with non-compliant policy forms to submit new policy forms, with language that reflects the limited grounds available for the denial, limitation, or termination of medical and hospital benefits found in WAC 284-30-395(1). At no point has the Commissioner, or his staff, communicated a contrary interpretation of WAC 284-30-395(1). Based on the plain language of WAC 284-30-395(1), no carrier can use additional requirements, including "maximum medical improvement" as a basis for denying, limiting, or terminating medical and hospital coverage under PIP. Therefore, the answer to the first certified question is yes, an insurer does violate WAC 284-30-395(1) if that insurer denies, limits, or terminates an insured's medical or hospital benefits claim based on a finding of "maximum medical improvement".

B. The Term "Maximum Medical Improvement" Could Be Used Consistently With WAC 284-30-395(1), But Only If That Term Is Not Used To Create A New Barrier To Coverage Of Medical And Hospital Services

Because neither WAC 284-30-395(1), nor RCW 48.22.005(7) define the terms "reasonable" or "necessary," a carrier could potentially use a term such as "maximum medical improvement" when defining what "reasonable" and "necessary" mean under its particular contracts. However, such definitions cannot add another requirement to the coverage of medical and hospital services that does not already exist in statute or

WAC. One appropriate manner of defining "reasonable" and "necessary" would be to presume that all services that aid in reaching maximum medical improvement are necessary. But a contract cannot, consistent with WAC 284-30-395(1) and RCW 48.22.005(7), define "necessary" as limited to treatment that leads to maximum medical improvement. This would be inconsistent with the statutory definition of medical and hospital benefits as "*all* reasonable and necessary expenses." RCW 48.22.005(7) (emphasis added). Interpreting WAC 284-30-395(1) in a way that allows carriers to eliminate certain types of medical and hospital services would allow carriers to eliminate nearly all medical and hospital services by simply defining them as "unnecessary." This has the potential to make PIP coverage largely illusory for most consumers.

It is important to remember that carriers are already protected from ballooning PIP costs by the hard monetary limits imposed on policies. Carriers are still only required to offer $10,000 in coverage for medical and hospital services, and payment is limited to expenses incurred within three years of the event. RCW 48.22.095(1)(a); RCW 48.22.005(7). In addition, carriers can always, on a case by case basis, argue that certain expenses are not reasonable or necessary. But carriers should not be permitted to create arbitrary obstacles to receiving medical and hospital services that are incurred as a result of a covered accident.

Therefore the answer to the second certified question is a qualified yes, the term "maximum medical improvement" can be consistent with the definition of "reasonable" or "necessary" as those terms appear in WAC 284-30-395(1), but only if its use does not create an additional grounds for denial, limitation, or termination of otherwise reasonable and necessary medical and hospital benefits under PIP coverage.

VII. CONCLUSION

Consistent with WAC 284-30-395(1) and RCW 48.22.005(7), the Commissioner, through his staff, has clearly communicated to State Farm and others that carriers may not arbitrarily limit medical and hospital services that are reasonable and necessary by manipulating policy form definitions. While carriers could potentially use terms like "maximum medical improvement" in a way that is consistent with WAC 284-30-395(1), carriers must not be allowed to use unilaterally created definitions to eviscerate the protections the Legislature and the Commissioner intended

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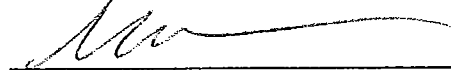
to provide for those purchasing PIP coverage.

RESPECTFULLY SUBMITTED this 25th day of January, 2018.

ROBERT W. FERGUSON
Attorney General



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Appendix A

CONCISE EXPLANATORY STATEMENT
PIP -- R 96-6

Filed pursuant to RCW 35.05.325(6)

Background

On August 13, 1996 (WSR 96-17-028), Insurance Commissioner Deborah Senn filed a Preproposal Statement of Inquiry and notified the public that she was considering adopting rules to set minimum standards for the termination, denial, or limitation of Personal Injury Protection (PIP) benefits in personal auto insurance policies. She noted that she has received several requests from members of the public to adopt consumer protection standards. A review of the consumer complaint data base showed about 700 complaints in less than five years about the way insurers deny, limit, or terminate PIP benefits, many after a cursory review of records, some after "independent medical examinations." A pattern of inadequate disclosure of benefits and claims procedures at time of claim emerged.

Members of the Commissioner's staff evaluated the requests from members of the public and informal as well as formal meetings were held with interested persons. A proposed rule was published on October 23, 1996 (WSR 96-21-140). Written comments were presented and a rule-making hearing was held. After reflecting on the comments, Commissioner Senn proposed substantive changes and submitted a new proposed rule-making notice on January 16, 1997 (WSR 97-03-090).

More meetings with interested persons were held and written comments received and evaluated. A rule-making hearing was held on February 25, 1997 at which Commissioner Senn presided. The record was held open until March 3, 1997 for the presentation of additional materials for inclusion in the formal rule-making file. Comments were received after the record was officially closed. all comments received prior to the adoption date of June 4, 1997, were considered and evaluated.

The most significant change between the rule as proposed in October and the rule as proposed in January is the requirement that the reviewing professional have the same license as the treating professional being reviewed. The most significant changes between the rule as proposed in January and the rule as adopted on June 4, 1997 are: (1) the deletion of the requirement for reconsideration of appeal of a determination to deny, limit, or terminate PIP benefits (old subsection (3)); (2) where an insurer reviews the treatment of multiple health care professionals, the review shall be completed by a

professional with the same license as the principal prescribing or diagnosing provider, unless the insurer and insured agree otherwise; and (3) when providing a written limitation of benefits under subsection (2) of the rule, the insurer shall provide the insured with copies of pertinent documents, if requested by the insured.

The Commissioner determined it advisable to set subsection (3) aside for the time being due to the practical difficulties and expense associated with its administration. Testimony indicated that significant numbers of PIP claimants are treated by multiple professionals; the change requires an insurer who wants to review the entire course of treatment of an insured to use a professional with the same license category as the principal prescribing or diagnosing provider, however, if the review is of only a single provider, the reviewing professional should have the same license as the provider under review. A number of persons providing testimony indicated that if a copy of the documents relied on was provided to the insured, it would be easier to determine whether the insurance company was relying on incomplete information.

Other changes were editing only.

The Commissioner's reasons for adopting the rule:

Many persons requested that Commissioner Senn review the current practices of insurers and establish minimum standards for claims determinations of PIP claims. The Commissioner's office has received more than 700 complaints in less than 5 years about the way insurers deny, limit, or terminate PIP benefits, many after review of the insured's treatment records or an "independent medical examination" or IME. After a cursory review of the claim files and several conversations with representatives of several PIP insurers, a pattern of inadequate disclosure of benefits and procedures at time of claim emerged. Conversations with policyholders, insurers, trial attorneys, chiropractors, and others confirmed this pattern.

It was established that insurers and insureds have difficulty understanding each other when it comes to coverage for PIP benefits, particularly at time of claim. Disclosure at the point of claim is a reasonable solution to this lack of understanding.

Summary of the rule as adopted:

The rule requires an insurer, as soon as possible after the insured presents a PIP claim, to advise its insured in writing that the company may deny, limit, or terminate an insured's medical and hospital benefits. If a claim is denied or limited, the insurer must provide the "true and actual" reason for its action in terms that explain the reasons for the insurer's act and that can be understood by the insured; and, if the insured requests it, the insurer shall provide the insured with copies of pertinent documents.

Medical and health professionals that review records must be currently licensed, certified, or registered in the same health specialty as the insured's treating professional. If the insured is being treated by more than one health professional, the review must be completed by the principal prescribing

provider, unless the insured and the insurer otherwise agree.

Insurers must maintain information in the insured's claim file to allow the commissioner to verify the credentials of the reviewer at a later date.

Insurers may not deny property damage claims of insureds that do not participate in IMEs.

Minimum standards for the application of PIP arbitration provisions are set forth.

The differences between the text of the proposed rule as published in the *Washington State Register* and the text of the rule as adopted (other than editing changes) and the reason the changes were made:

Subsection (2) of the proposed rule was amended to require an insurer, when providing a written limitation of benefits, to provide the insured with copies of pertinent documents, upon request.

Subsection (3) of the proposed rule, requiring a reconsideration or appeal of a determination to terminate, deny, or limit benefits, was eliminated, and the subsequent subsections were re-numbered.

Subsection (4) of the proposed rule, renumbered to be subsection (3) in the adopted rule, was amended to require that if an insured is being treated by more than one health professional, any professional review should be completed by the principal prescribing or diagnosing provider, unless the insured and the insurer otherwise agree.

All other changes were editing changes.

Summary of all comments received regarding the proposed rule; response to the comments by category or subject matter; and how the final rule as adopted reflects the Commissioner's consideration of the comments, or why the final rule failed to reflect the comments.

See Attachment A for a summary of comments received and the Commissioner's response thereto.

See Attachment B for a brief economic analysis of the effects of the rule.

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June 4, 1997

ATTACHMENT A TO CONCISE EXPLANATORY STATEMENT -- SUMMARY OF COMMENTS ON PIP RULE, RESPONSES R 96 - 6

During the period January 16, 1997 through March 6, 1997, 25 pieces of written comments were received into the rule-making file from persons, companies, or associations. An additional 39 pieces of written comments were received after the record was closed. All comments received prior to the adoption date, June 4, 1997, were considered. Below is a summary of those comments and the Commissioner's responses, as required by RCW 34.05.325(6).

General

This is a good rule: This version of the rule clearly favors and protects insured consumers as it requires insurers to comply with the terms of the policy and deal with policyholders in good faith, prevent a claim denial because the treatment is palliative, and the relaxed rules of evidence in policy arbitrations will enable consumers to achieve more expedient and economical resolutions of claims.

RESPONSE: Thank you. Adequate disclosure of policy provisions and limitations at time of claim are important consumer protections.

Statutory authority: The proposed rule exceeds the authority of the Commissioner. The authority cited does not grant the commissioner the power sought to be exercised in this matter. The Legislature should be the body that requires the notice that is the subject of this rule if it thinks this action is required.

The statute provides the grounds for denial, limitation or termination of PIP benefits; if the Legislature wanted additional detail it would have provided for it. The Commissioner has failed to show how many of the 700 complaints she has received provide valid rationale for this regulation; she has failed to show how many of these complaints are valid.

Evidence does not support the underlying assumption that the current utilization review practices of insurers are erroneous and unfair to policyholders.

This regulation is not consumer protection; it adds an additional consumer cost that policyholders will pay.

RESPONSE: The rule does not exceed the statutory authority of the Commissioner to adopt an unfair practice rule. See RCW 48.30.010 and Omega v Marquardt, 115 Wn.2d 416, 799 P.2d 235 (1990). In addition to a review of the complaints data base, several insurers were contacted to describe their PIP claims activities. A common thread throughout the investigation is problems with adequate disclosure to consumers. Even complaints that do not result in disciplinary actions can be "valid" if a consumer is confused or mislead.

The rule as proposed is overly broad. Not all PIP denials involve the issue of the frequency and extent of chiropractic care.

RESPONSE: The rule does not affect only the "frequency and extent of chiropractic care."

Subsection (3) creates an entirely new appeal/reconsideration right, a second level of appeal as to a PIP benefit determination and the insurer's expense.

RESPONSE: While we do not believe that the subsection (3) reconsideration requirement exceeds the Commissioner's rule-making authority, this subsection was not adopted and a review of the practical problems and associated expenses may be reconsidered at a later date.

The RAND study documents that there is an overall excess in medical costs in Washington of 45% to 53% which equates roughly to $125.00 to $145.00 per insured, and that this is substantially higher than the national average. Washington drivers claim to have suffered soft tissue injuries at abnormally high rates and tend to utilize abnormally large amounts of medical care for all types of claimed injuries.

PIP coverage is a unique health insurance benefit; it has none of the cost containment mechanisms of other health insurance such as deductibles, co-payments, preauthorization provisions, or managed care elements. Unlike casualty insurers, health care insurers have negotiated preferred provider rates with service providers. It is a system without checks and balances; it is a soft target for those who seek to take advantage of the system. The IME or paper review serves to provide some measure of cost containment.

There needs to be a fair balance between claimants and insurers; this rule tips the balance in favor of claimants.

This rule will make it difficult for insurers to carry out the statutory mandate that only reasonable and necessary expenses qualify for PIP coverage.

RESPONSE: While the RAND statistics may be true and are certainly disturbing, it is our belief that timely disclosure to policyholders of their policy provisions and claims handling limitations will be beneficial to both insureds and insurers and will discourage presentation of fraudulent claims. The rule is not designed to address the relative costs of Washington claims or to obstruct utilization review. The goal of the rule is a better educated consumer.

Other more appropriate remedies exist: The proposed rule is unnecessary since those aggrieved by an adverse decision concerning PIP benefits have other remedies for reinstatement of benefits. This rule does little more than add additional regulatory burdens and claims handling expense which ultimately will be borne by the insurance purchasing public.

These rules will be used to game the system and to cripple insurance companies efforts to combat fraud and delay the ability to review medical treatment.

RESPONSE: Based on the Commissioner's review of consumer complaints and conversations with insurers, it is clear that a disclosure requirement is an appropriate remedy for the confusion policyholders exhibited.

Procedural issues: The Commissioner is attempting to adopt an "interpretive rule"; however, the rule

seems to meet the definition of a "significant legislative rule" since it "adopts substantive provisions of law pursuant to legislative authority, the violation of which subjects a violator of such rule to a penalty or sanction." (See RCW 34.05.328(5)(c)(iii)(A).)

RESPONSE: We believe that this rule is an interpretive rule. That said, the Commissioner fully considered all aspects of the effects of this rule, including the implementation costs and determined the implementation costs to be minimal. A brief economic analysis of the necessity, benefits, and costs of implementing this rule is included as "Attachment B" to the Concise Explanatory Statement.

You say that the costs of implementation are minimal and reflect the practices of many insurers. These statements are incorrect, particularly the reconsideration in subsection (3) and the limitation on using consulting health care professionals in subsection (4).

RESPONSE: Subsection (3) was not adopted. We do not believe the costs associated with implementing subsection (4) are significant -- see Attachment B to the concise Explanatory Statement.

Preamble

Insureds are outraged to find out that the premiums they have paid do not secure the coverage they thought they purchased.

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

You say that PIP benefits are a significant cost element, yet this rule only adds to the cost of auto coverage. There is nothing in the rule to lower the cost of auto insurance.

RESPONSE: This rule may not directly lower the cost of auto insurance; however, we believe that when insureds understand the coverage provisions of their policies, claims litigation will be reduced, thereby slowing the inevitable increase in the cost of auto insurance.

Adequate regulatory mechanism to make sure that insureds receive adequate explanation is already in place: WAC 284-30-330(13), for example.

RESPONSE: We agree that WAC 284-30-330(13) provides consumer protection. In response to a number of requests from consumers that are obviously confused about their PIP benefits and claims, the Commissioner determined it is appropriate to adopt a rule specific to PIP claims disclosure and claims administration issues reasonably related in time to the presentation of a claim. People often forget what was promised or discussed at the time they purchased an insurance policy.

"Adequacy and appropriateness" of treatment are not the same as"reasonableness and necessity" of treatment. The terms "reasonableness and necessity" should be substituted for "adequacy and appropriateness."

RESPONSE: You're right. Thank you for the comment -- this editing change was made before adoption.

You refer to the "cost of automobile liability insurance" and "personal injury protection benefits in an automobile liability insurance policy." PIP benefits are first party benefits; "liability" should be deleted.

RESPONSE: You're right. Thank you for the comment -- this editing change was made before adoption.

Subsection (1)

This rule does not address the practice of many insurers not paying bills as they are submitted, collecting several months worth of bills, and then denying all retroactively after an IME.

The rule does not address the situation where bills for treatment are incurred between the date of the letter requesting an IME and the date of the IME report denying further benefits. Insurers do not pay these bills.

All bills should be paid within 30 days of submission.

Define in days the term "reasonable time" -- otherwise courts will have to define it each time.

RESPONSE: Both the insured and the insurer have an obligation to timely submit or respond to claims. The PIP law requires insurers to pay only "reasonable and necessary" expenses, not all bills submitted. Specific time limits already exist in rule, for example: WAC 284-30-370 requires insurers to complete investigations within 30 days; WAC 284-30-360 requires acknowledgment of pertinent communications within 10 days or 15 working days; 284-30-380 requires insurers to advise of acceptance or denial of claims within 15 working days.

The insurer should be required to pre-authorize procedures within 5 working days of a request.

RESPONSE: Generally, PIP benefits do not require "pre-authorization" and any requirement for a change in PIP benefits is appropriate for review by the Legislature.

This subsection should be deleted because it conflicts with the scope as set forth in the introductory paragraph and will improperly prohibit insurers from relying on some legitimate defenses to deny, limit, or terminate PIP benefits. It could be construed to mean that an insurer cannot deny benefits for other reasons such as non-cooperation or breach of policy provisions, for example.

RESPONSE: This subsection only applies where benefits are denied, terminated, or limited based on a medical evaluation. This subsection does not operate to abrogate contract terms or the statutes of limitation. A denial for breach of contract provisions or other operative law is not eliminated by this rule.

This notice gives customers the impression that there is a problem and creates a barrier to good service. This is a terrible way to start the claim process.

RESPONSE: Companies send out proof of loss or claim forms for completion by the insured. At that time instructions for presenting claims are included which can also include a notice that not all bills will automatically be paid or reimbursed. This need not be an adversarial notice. According to our records, many insurers already provide this type of notice.

Clear language in the PIP policy notifies consumers that insurance payments will not be made for unreasonable or unnecessary expenses.

RESPONSE: It is the experience of the Commissioner and others that insureds believe that 100% of all bills presented, up to the limit of the PIP benefit, will be paid without question. After reviewing complaints and claims procedures, we determined that a rule that provides for disclosure at point of claim will provide great assistance to insureds.

What about policy limits? fraud? The list of possible reasons for denial is confusing.

RESPONSE: The list reiterates the statutory reasons to limit benefits. Contractual reasons may apply as well.

Insurers should be required to bring bills current before the day they elect to do an IME or records review. PIP carriers should be prohibited from retroactively terminating benefits.

RESPONSE: This is a difficult issue because PIP benefits are "indemnity" benefits that are always, by definition, reimbursement for treatment already received. We know of no Washington PIP benefit constructed in a way that requires pre-authorization for treatment. In addition to the comments above, we we told that some insureds and providers present bills for treatment only after a course of treatment is completed or significant treatment has been undertaken. Generally, the Commissioner believes it is inappropriate for an insurer to deny payment for treatment already undertaken without notice to the insured that this will happen. The notice required by this subsection was designed to address this specific issue.

Subsection (2)

You should require the PIP carrier to give a copy of the reviewer's report to the insured. The insured is not in a position to rebut or challenge the information contained in the reviewer's report without a copy. PIP insurers should be required to keep a list of the reviewers together with their qualifications. I find that many times the insurer's response is made on incomplete information; providing a copy of the report would allow an insured an opportunity to provide additional information if the record relied upon by the insurer is incomplete.

RESPONSE: A number of passionate comments along this line were received. The rule

was amended at adoption to require the insurer to provide the insured with pertinent documents if the insured requests them when the insured denies, limits, or terminates PIP benefits. The Commissioner sees the value of receiving copies of reports relied upon, if the insured wants a copy..

Insurers should be required to state why they have chosen not to rely on the opinions of the treating professional before they even ask for an IME. Or do you intend that this is required in subsection (2) of this rule?

RESPONSE: An insurer must already give the reasons for limiting, terminating, or denying benefits. (See, for example: WAC 284-30-330(13) and 284-30-380.)

What is the benefit of this second letter? We've already sent the information in the first letter required by subsection (1).

RESPONSE: The disclosure required in subsection (1) is at time of first notification of a possible claim - a pre-submission disclosure. Subsection (2) regards disclosure at the time an action is taken to limit a PIP claim - an informative statement of the reasons for the action.

Providing an explanation in clear and simple language so that the insured need not resort to additional research to understand the reason given imposes an impossible obligation on insurers. We do not know the level of understanding of any particular claimant. The standard of a "reasonable person" should be substituted.

RESPONSE: The insured is the one who needs to understand the insurer's actions. Insurers should already be using this standard for terminations and non-renewals (WAC 284-30-570), so it should not be an "impossible burden." The idea is that the company's action should be clear and complete -- the response that would make sense to you if you were an insured unfamiliar with insurance "lingo" or insurance policy limitations.

Subsection (3)

This subsection only increases claims handling costs. If it is retained it should be clarified to state that, since the insurer bears the cost of the professional review, the selection of the reviewer remains solely at the option of the insurer.

Most claimants will see this as a free service and will automatically ask for reconsideration, but this is not free; all purchasers of PIP coverage will have to pay the price for mandatory reconsideration.

The insured should not have to pay the expense of submitting additional information as contemplated in this subsection. All charges should be borne by the company.

The medical review provisions are expensive. To give every claimant two reviews under this bill is absurd. If claims are improperly denied, that should be dealt with in a Market Conduct Examination.

The claimant always has an opportunity to resort to the courts as a remedy for improper denial or

termination of PIP benefits.

Please distinguish between "appeal" and "reconsideration" as used in this subsection.

How do you intend to have this subsection apply where a panel has completed the IME. If a panel IME was done, does that mean that the insured can request a reconsideration for each of the specialties involved or that the insured can request an IME done by a second panel ?

Insureds do not necessarily select providers that provide objective opinions; the reconsideration is an unnecessary expense because opinions of qualified providers rarely differ. This subsection will require expenditure of far too much money at too little benefit.

This subsection will only benefit health care professionals, not insureds.

RESPONSE: After full consideration of the possible costs and practical considerations raised by the comments, this subsection was not adopted. A review of the practical problems and expense associated with a reconsideration of an adverse determination may be reconsidered at a later date.

Subsection (4)

This requirement is absurd.

This provision goes far beyond the statutory authority of the Commissioner.

A licensed physician is well able to make a determination as to any person providing treatment.

This provision will require insurers to contract with aroma therapists, massage therapists, and the like. This will not provide any better review process; in fact this will contribute only to higher PIP costs.

RESPONSE: The intent of the rule is to safeguard the insured's choice of professional provider and to respect the professional providing the care. The above comments represent an overly-broad interpretation of the consequences of this rule.

This subsection is unclear, too restrictive, and will needlessly increase claims handling costs. Professionals may end up giving opinions regarding injuries that they are not qualified to treat.

Insurers have an obligation to keep premium costs down. Insurers have a statutory obligation to review all claims for reasonableness and necessity.

This rule will make it impossible to combat fraud and contain costs. Restricting review to a professional in the same license category as the treating provider will hurt insurers' efforts to control costs and investigate fraud. Review of many claims will have to be abandonded. The focus should be on the nature of the injury; insurers should be able to rely on the expertise of any practitioner who treats the injury in question.

This subsection may be inappropriate, unfair, unworkable, and result in unnecessary inconvenience for claimants and inordinate expense for insurers. This subsection fails to take into account overlap in expertise among various specialities or that the injured insured may have consulted multiple specialists. Many specialists are competent to treat neck and back pain; often these symptoms are treated by nonspecialists. Does this rule require a family practitioner's treatment of back or neck pain to be reviewed only by another family practitioner instead of a specialist who would be better qualified to render an

opinion?

Many specialities cross over in their expertise, such as orthopedics; we are quite capable of evaluating back injuries, which may also be treated by neurologists, neurosurgeons, osteopaths, or chiropractors.

You should return to the language of the first proposed PIP rule and reinstate the language: "or in a field or speciality that typically manages the condition, procedure, or treatment under consideration."

RESPONSE: This rule does not interfere with a reasonable review for reasonableness and necessity of treatment. Insurers told us that most companies now have treatment reviewed by a professional in the same license category as the treating professional.

The Commissioner considered returning to the original draft[1] and rejected it. Our research indicates that this rule will not significantly add to the costs of administering PIP claims, will protect the consumer's choice of treating professional, and will not interfere with the doctor-patient relationship.

Most companies use the same specialty as the treatment provider; however, in some cases, such as where we see evidence or a suggestion of symptoms indicating a condition that is not being addressed, we may do an IME or record review with a speciality that treats that condition. Sometimes we see a history or symptoms that are not being addressed by a provider and order an IME in another specialty. An IME in the same specialty will not be of assistance. We cannot ignore these symptoms and hope the insured happens to go to another practitioner qualified to treat their symptoms. Patients reveal different parts of their history or symptoms to different providers; the insurer will see all of the reports and records. This subsection will prohibit companies from considering the best treatment of the patient.

RESPONSE: We assume that insurance companies will not shirk their ethical or professional duties as a result of this rule. We do not believe that the subsection prohibits companies from considering the best treatment of the patient; on the other hand, we continue to believe that it safeguards the doctor-patient relationship.

Some specialists are few in number and a competent reviewer with the same license may not be readily available, particularly in the non-urban areas of the state.

RESPONSE: We have not received any evidence that there is a lack of professional reviewers which will cause a hardship; however, if evidence surfaces we will review the issue and consider an amendment to the rule at that time.

Sometimes specialists are unwilling to testify against a colleague; this subsection only makes it

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[1] " (5) Health care professionals upon whom the insurer will rely to make a decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered in this state to practice in the same health field or speciality as the treating health care professional or in a health care field or speciality that typically manages the condition, procedure, or treatment under consideration. . . . ." See: WSR 96-21-140.

more difficult to review treatment.

RESPONSE: The willingness of one professional to testify against another is not a result of this rule; we do not agree that this rule makes it more difficult than it is now.

What is most important is the reviewer's qualifications by virtue of education, training, and experience, not what degree, license, or board certification a reviewer or examiner happens to possess.

This subsection does not take into account the varying qualifications of health care providers and should not be mandated by an inflexible rule.

Review of medical claims by an insurer must be performed by qualified medical persons. An IME or peer review is an appropriate method.

RESPONSE: This rule does not eliminate IMEs or peer reviews. We agree that the reviewer's qualifications by virtue of education, training, and experience are tremendously important and that peer review is the most appropriate method to assure consistent and quality treatment.

It is not uncommon for multiple providers to have provided treatment; this subsection might require an independent exam in an auditorium where members of several specialities examine the individual or would require an equally numerous number of evaluations at separate times and different locations. This would only inconvenience the insured, perhaps at great loss of income, and would represent a scheduling nightmare at extraordinary cost to the insurer.

RESPONSE: After a review of the issues of multiple professionals treating a single patient, this subsection was amended. Where there is more than one provider, the review should be completed by the principal prescribing or diagnosing provider unless the insured and the insurer agree to another reviewer. We believe that this is the fairest and most equitable solution to this issue.

We adopt this amendment to (new) subsection (3) assuming that a diagnosing provider is "controlling" the plan of treatment. Where that is not true, or where a limited treatment plan is being considered, for example, it is contemplated that the insured and the insurer will reach an agreement regarding how an appropriate peer review will be completed.

This change may be an imperfect solution to this issue; we plan to watch how this works and are open to amending this subsection if it proves unworkable in practice.

Providers conducting IMEs should be required to have malpractice insurance and disclose the carrier and policy number. The insured should be allowed to choose not to be examined by a medical provider who does not have professional liability coverage.

The rule should further state that any party conducting an IME or other review whose license is suspended, revoked, or impaired may not testify and the IME results may not serve as the basis for a denial of benefits.

RESPONSE: These are interesting suggestions; however, the Legislature repealed the requirement that health care professionals must carry malpractice insurance; the

Insurance Commissioner is not in a position to impose rules on a court as to who may or may not testify.

Subsection (5)

Keeping credentials in a claims file is burdensome and provides no consumer benefit.
RESPONSE: This requirement is included as a benefit the Insurance Commissioner's Market Conduct Examiners. An insurer could satisfy this requirement by establishing a central registry with a code in each insured's file. If the required information is not complete in each insured's claim file, records must be kept in some centralized place for a prolonged period of time in order to be sure that a cross-reference coding system works at a future date. When an Examiner visits the insurer, he or she must be able to easily determine the credentials of the health care professional upon whom the insurer relied; any logical system is acceptable.

Subsection (6)

This subsection is unnecessary; it is already addressed by WAC 284-30-330(12).
RESPONSE: This subsection was added because of a number of incidents related specifically to PIP.

This subsection sends a mistaken message to claimants that somehow their contractual obligation to participate in an IME has been weakened.
RESPONSE: We disagree with this statement.

Subsection (7)

This subsection is most disappointing. PIP arbitration should be the same as UIM arbitration. Insurers should be required to pay the costs of arbitration. Most insureds cannot afford to pay their doctor to appear at the hearing; this can cost between $500 and $1,000. Insurers know this and use it to intimidate their own insureds into accepting their decision as final without appeal. It should be improper for insurers to state or imply that the insured may have to pay the arbitrator. "The rule should state that at arbitration the insurer has the burden of proving the basis for its denial on the evidence on which the denial was given."
RESPONSE: The Legislature has set forth the benefits of PIP coverage and UIM coverage in separate laws; these laws are not parallel. As a result, application of UIM case law to PIP is not necessarily appropriate. Additions or deletions to the PIP benefits, such as mandatory arbitration or payment of attorneys fees for insureds, should come from

the Legislature.

In subsection (7)(c): these rules could be better identified by reference to MAR 5.3, 5.3(d)7 and ER 904.

RESPONSE: We prefer not to adopt a rule that incorporates by reference sections of rules of other agencies or entities.

The regulation as written will require forms to be refiled. Please re-write to provide that arbitration should be conducted in accordance with the regulation rather than have the provisions in the contract form.

RESPONSE: Good idea. Done.

Washington Arbitration and Mediation Service (WAMS) objects to listing of private organizations because it implies that WAMS and other organizations with recognized mediation rules are intended to be excluded. WAMS is harmed by this language.

RESPONSE: We do not believe that this language is exclusionary. It is not meant to exclude WAMS or any other recognized organization, merely to give examples. WAMS is now included in the reference. We will take care in the future to make certain such language is not exclusionary.

Miscellaneous

Where are the teeth in this regulation? Companies should have to pay a fine if they deny, limit, or terminate PIP benefits where the arbitrator determines that action to have been wrong. This fine should be separate and distinct from any action under the Consumer Protection Act.

RESPONSE: There are teeth in this rule and throughout Title 284 WAC. These "teeth" are separate and apart from the Consumer Protection Act. If the Commissioner determines that an insurer is violating this rule, the Commissioner may fine the company or may revoke the company's Certificate of Authority to insure residents of this state (see: RCW 48.05.140 and 48.30.010). The Commissioner cannot create a private right of action.

The rule should prohibit an insurer from charging for its administrative costs for processing the insured's claim (copies of police reports, medical records, property valuation service charges) to the insured's PIP limits; only payment of medical bills should be charged to the PIP limits.

RESPONSE: Even without this rule, an insurer is not permitted to charge its administrative costs against the insured's PIP limits.

Deferral or reduction of bills determined not to be reasonable or necessary can only be appealed by the medical provider. Because the bill is not "denied" the insured's standard heath carrier will not make

payment. This places the insured and his or her medical provider in an adversarial position focusing on payment of bills rather than medical treatment.

Allstate only pays what the company thinks is appropriate; the current draft applies only to consultation with health care professionals; it should be expanded to prohibit an insurer from "shaving" medical bills.

RESPONSE: The Insurance Code (Title 48 RCW) and rules promulgated thereunder (Title 284 WAC) protect consumers and regulate the contracts between the insurance company and the policyholder or insured; these Titles do not include protections for providers of professional services. The PIP statutes require an insurer to pay only the "reasonable and necessary charges."

As we understand it, the issue described above involves a disagreement between the insurer and the provider; it is not related to the provisions of an insurance contract. We are concerned when insureds are put in the middle of a disagreement between the provider and the insurance company as to the appropriateness of a charge for services. We have been assured by insurers that they will protect their insureds in any collection action of the provider.

Some insurers ask for IMEs even after benefits have been cut off.

RESPONSE: It is possible to imagine circumstances where this action is appropriate and when it might not be appropriate. We will continue to watch for issues such as this as we monitor the effectiveness of this rule.

Comments outside the scope of this rule-making

The following suggestions for additions to the rule are outside the scope of this rule-making. Many of the comments are more appropriate for legislation. The Commissioner's authority does not extend to over-ruling decisions of the courts. The Commissioner's staff will continue to monitor PIP complaints and will evaluate whether this rule should be amended, clarified, or expanded at a future date. Many of these practices are prohibited or limited by existing rules.

You should adopt a rule that the reports of these PIP IME's cannot be discoverable in third party litigation thereby overruling the decision in Johnson v McKay, 77 Wn.App. 603 (1995) or somehow limiting Division III's decision in Johnson. IME's are being used in third party cases against the insured.

You should add a new requirement: "There shall be no particular format required for submission of PIP benefits by way of a particular claim form or format. However, the claimant shall be required to provide all relevant information reasonably necessary for the carrier to assess the claim, determine its validity and decide whether or not to pay." This would make it harder for insurers to try to wear down claimants by making the benefits hard to obtain, including requirements to resubmit materials several times.

You should add a new requirement: "It shall be considered an unfair claims settlement practice to threaten claimants with litigation or imposition of attorneys' fees for claimants asserting rights of

reimbursement under their PIP policies." Most insurers do not believe that Thiringer applies; they "dust off" claimants.

You should add a new requirement: "Wherever a carrier under a PIP policy requires a claimant to take or undergo a medical examination as a precondition for receiving PIP benefits or the continuation of PIP benefits, PIP carriers shall state the grounds therefor, in writing, to the claimant. Repeated medical examinations will be strictly prohibited unless extraordinary circumstances are present. Extraordinary circumstances are defined as circumstances which were not reasonably foreseeable to the carrier at the time the request of the original medical exam." Carriers sometimes require second or third examinations which serve no legitimate purpose other than to inconvenience the claimant.

You should add a new requirement: " In the provision of PIP benefits, an insurance carrier may not designate a specific provider of services or benefits which must be used by the claimant as a condition of benefits. No such 'tying agreement,' arrangement or relationship shall be required of a PIP claimant, and the claimant may choose any reasonably competitive provider of goods or services at the claimant's option without waiving reimbursement." Steering to certain rental car agencies or similar providers should be prohibited.

You should add a new requirement: "Whenever a claim has been settled by a claimant's attorney and there has not been a specific, written denial or disclaimer of representation by the involved PIP carrier, and benefits are received, PIP carrier will be charged with its proportionate share of fees and costs for the collection of those benefits." This is the law under Pena v Thorington, a Division III case; nevertheless, even where carriers accept benefits they frequently insist that they are not liable for reimbursement of attorneys' fees or costs.

You should add a new requirement: "If a dispute arises with regard to an intercompany repayment of a subrogation interest in PIP benefits, which is contested by the claimant, it shall be an unfair settlement practice for one company to pay to the other company such benefits without the consent of the claimant. Such payments shall constitute an unfair settlement practice and/or deceptive act of [sic] practice, pursuant to RCW 19.86.010 et seq. Any payment contested by a claimant shall be held by the respective carrier until the matter is resolved by arbitration, court order or consent." A third party liability carrier should be prohibited from paying the money "around" the claimant directly to the PIP carrier; the PIP carrier has refused to reimburse the claimant and threatened a counter-suit when the claimant made a demand.

You should add a new requirement: "These administrative regulations shall be construed broadly in favor of the consumer of insurance services and consonant with the duty of the first party carrier to act, at all times, with good faith, fair dealing and with full disclosure of all relevant facts." Anyone who has dealt with PIP carriers has seen the lengths to which they go to preclude having to pay claims.

Examinations under oath should be eliminated.

Medical examinations by insurers should be eliminated.

You should add a new requirement: "Insurers may not use reports from consultants who are not licensed health care providers to deny PIP benefits, such as collision reconstructionists."

An IME (a/k/a Independent Medical Exam in most insurance contract language) should be called an "Insurance Medical Exam" -- there is nothing "independent" about an IME.

You should include a new requirement: "Insurers should be required to report the frequency of PIP

IME requests and the frequency of denials following an IME."

You should add that an insured has the right to make an audiotape recording of a PIP IME.

Attachment B to Concise Explanatory Statement -- Brief Analysis of Probable Costs and Benefits of Proposed PIP Rule

R 96-6

The Insurance Commissioner has the responsibility of protecting consumers against unfair practices in the insurance industry. In August, 1996, the Commissioner proposed the drafting of a rule with the intention of preventing unfair settlements of Personal Injury Protection (PIP) auto insurance claims. Since August, the Commissioner has held two rule-making hearings and has solicited comments regarding the proposed rule and PIP insurance. This rule has undergone many substantial changes since the beginning of the rule-making process. This report analyzes these changes and the requirements of the proposed rule that have been repeatedly brought up as issues of concern by parties interested in the regulation of PIP coverage.. This report emphasizes the final stages of the rule-making process and summarizes recommendations based on economic analysis and changes made to the rule as a result of these recommendations.

Introduction

The rule-making staff of the Office of the Insurance Commissioner (OIC) conduct evaluations of probable costs and benefits of proposed rules on an ongoing basis. This is a dynamic process in which the potential costs and benefits of various aspects of the rule are evaluated throughout the drafting process using common sense criteria. This enables the analysis to play a meaningful role in shaping the outcome of the rule drafting process.

This report is designed to reflect this dynamic process, emphasizing the final stages of the rule-making process. Parts I and II of this report identify the aspects of the rule that would potentially impose costs on insurers and describes the probable costs and benefits of each of these requirements. Part III discusses the policies of other agencies regarding similar issues. Part IV describes the recommendations produced by the evaluation process and summarizes how the rule has been altered in response to these recommendations. Attached, Appendix A provides a list of some of the cost-minimizations efforts that have taken place since the inception of the rule-making process.

PART I
DISCLOSURE

The proposed PIP rule requires two new forms of disclosure with regards to PIP claims: (1) After the receipt or notice of an insured's intent to file a personal injury protection medical and hospital benefit claim, an insurer is required to provide the insured with a written explanation of the medical and hospital benefits and limitations of their coverage. (2) After an insurer concludes it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer must advise the insured in writing.

Probable Costs of Disclosure

In previous analyses, including the Small Business Economic Impact Statement that accompanied the CR-102 filing of this rule, the requirement of a letter of notification was identified as a source of a potential cost impact on insurers. Since the inception of the rule-making process, this potential cost has been mitigated to a negligible amount (see Appendix A). In previous drafts of the rule, insurers were required to mail and maintain proof of letters notifying policyholders of the insurer's right to deny medical benefits upon review. After receiving feedback from insurers, this rule was modified to reflect the insurers' current practices as much as possible while preserving consumer protections by requiring adequate disclosure. Because an estimated 95%[1] of all insurers already require submission of written claims and provide instructions on filing in writing, the probable cost of this requirement was reduced from $1.00 (cost to mail and maintain proof of letters) per claim to a simple insertion to an existing letter for the vast majority of insurers. For the estimated 5% of the insurers that may not currently be sending letters to potential claimants, the cost would be approximately $0.40 per claim to draft, print, and mail a cover letter containing required information when sending out proof of loss or claim forms.[2]

Cost Assumptions

During a rule-making hearing held on February 26, 1997, the Farmers Insurance representative questioned the assumption that this proposed rule parallels the current practices of insurers with regards to letters of notification being sent to insureds after an accident and prior to a denial or limitation of medical benefits. Although it may be true that most insurers currently do not send letters which include all of the information required by

[1]Estimation based on a phone survey (Oct, 1996) and confirmed by data collected on three of the largest auto insurers in the state of Washington (1996).

[2]Cost information provided by SAFECO.

this proposed rule, the assumption that insurers already send letters to potential claimants, commonly enclosed with the claim forms, is supported by comments from carriers, a phone survey, and detailed data collected from three of the largest auto insurers in the market. Because the physical letter is the source of any cost impacts, it is important to note the validity of this assumption.

Probable Benefits of Disclosure

The purpose of requiring insurers to notify policyholders of coverage limitations before potential limitations occur is to clear up misunderstandings that may arise simply because the policyholders are not aware of the limitations of their coverage. To illustrate the potential benefits of requiring this form of correspondence, I use the OIC consumer complaints database and data from three major auto insurers in the market, taking special note of complaints that appear to arise out of misunderstandings of one form or another. To narrow the search, I look at a sample of 28 complaints specifically regarding claim denials during one year (4/95-4/96). In this set of complaints, only once does the OIC compliance officer find the company to clearly be in error in denying benefits to the insured. The remaining complaints involve a variety of issues; however, almost all involve some form of misunderstanding.

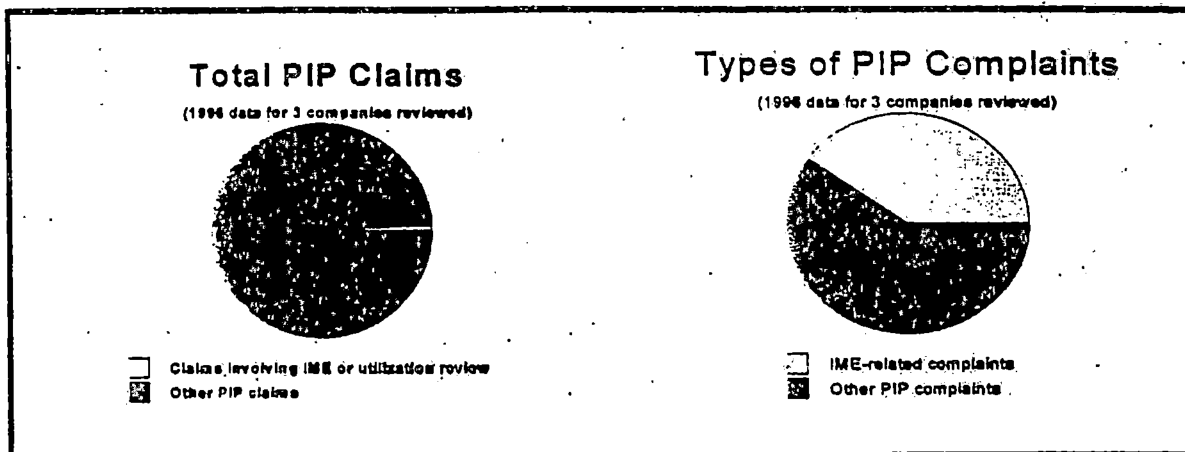
Approximately 29% of the complaints involve an Independent Medical Examiner's recommendation to deny or limit coverage in accordance with the contractual agreements (i.e. the company is found to have a basis for the denial of coverage). Many of the complaint files include statements claiming "... the company said they would pay for my [medical] bills, but now they are not..." Many of these persons filing the complaints claim to have not been aware that this coverage had limitations. An additional 21% of the complaints reviewed involve cases where the insureds claim either to not have been aware that they even possessed PIP coverage or that they had signed a waiver to deny PIP coverage (because an insured needs to explicitly request not to be covered by PIP, these complaints seem plausible). Thus, it appears that at least 50%[3] of the complaints in this sample may have been avoided if the insureds had been provided with additional information regarding the limitations of their coverage prior to filing a claim.

More detailed data collected from three of the largest insurers in the market appears to support conclusions regarding potential misunderstandings that take place when companies exercise some form of medical utilization review of PIP claims. The 1996 company data shows that although Independent Medical Examinations (IMEs) or utilization reviews are performed in less than 1% of the PIP claims for the companies included in the sample, they generate

[3]The remaining 50% of these complaints relate to a variety of issues including wage compensation, technicalities of claim filings, and pre-existing conditions.

approximately 40% (see Figure 1, below) of the PIP-related complaints. Insufficient disclosure may be the source of many of these complaints. For example, the layperson might see a benefit limit of $10,000 and assumes she will receive all medical benefits prescribed by her medical provider up to $10,000. The typical policyholder does not always foresee the limitations and/or may not realize that medical claims may be subject to review and evaluation. Adequate written disclosure clearly describing the benefits and limitations to the insured would provide the insured with information (or at least a reminder of the information) on which an insured should be making his decisions regarding the use of medical treatment.

Figure 1



Other Disclosure Issues

Some of the insurer representatives provided testimony stating that this form of notification would set up an adversarial tone for settling claims which may potentially hamper marketing efforts by their companies. At this stage, it would be difficult to assess this marketing concern; however, it is important to note that State Farm, for example, currently sends a letter containing the required information to all of its insureds upon notification of an accident. State Farm has managed to maintain the largest share of the private passenger auto insurance market in Washington state while making it a practice to send this letter to potential claimants. The actual tone of a letter is largely dependent on the phrasing and choices of language rather than the information presented. The proposed rule may require that additional information be presented to potential claimants, but it does not dictate the structure or the wording of the letter. The required disclosure includes policy information of which all insureds should be aware.

PART II
PEER REVIEWS AND INDEPENDENT MEDICAL EXAMS (IMEs)

There are two parts to the rule, as proposed, that deal with peer reviews and Independent Medical Examinations (IMEs): (1) The proposed rule requires insurers to provide a second opinion in the form of an additional peer review when requested by an insured[4]. (2) The proposed rule requires that health care professionals with whom the insurer will consult regarding its decision to deny or limit medical benefits should be currently licensed to practice in the same health field or specialty as the health care professional that is treating the insured.

Probable Cost Implications of IME Requirement

Cost Assumptions

The cost estimations are based on two assumptions: (1) Relatively few PIP claimants will be asked to attend an IME and peer review; and (2) For the most part, insurance companies already employ IME professionals that are licensed in the same field as the treating providers. During the hearing held on February 26, 1996, the Farmers Insurance representative questioned the assumption that this proposed rule parallels the current practices of many insurers with regards to types of medical professionals used by insurers to perform peer reviews. This assumption was used in previous analysis and continues to be a valid assumption, supported by comments from carriers, a phone survey, and current detailed data reviewed from three of the largest auto insurers in the state of Washington.

Most of the insurer representatives interviewed state that companies often utilize health care professionals in the same field as the treating professionals in order avoid potential complaints from the insureds and for legal purposes (in the event the case goes to trial, a health care reviewer in the same field often proves to be a more credible witness[5]). The 1996 data collected from the three companies confirms the validity of this assumption. This data reveals that out of a total of 177 PIP claims processed in 1996, only 3 cases (less than 2%) involved professionals that were not in the same field as the treating professional performing IMEs. Based on these results, it is reasonable to assume that insurers are already conducting IMEs with professionals in the same field as the treating professional in most cases. In addition, insurer representatives provided testimony which indicates that only a small portion of PIP claims (approximately 1% of all claims[6]) are reviewed by insurers using independent exams.

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[4]This provision was not adopted.
[5]This conclusion is based on interviews, a survey, and comments received from insurers.
[6]Percentage estimation offered by SAFECO representatives.

Based on these assumptions, any potential costs imposed by the requirements relating to IME professionals would only effect a very small portion of total claims (approximately 1.7% of 1% of all claims). When these costs are spread over the entire number of PIP claims filed in a given year (66,000 PIP claims were filed in Washington during 1995[7]), the potential costs per claim are minimal.

Insurer representatives provided testimony indicating that the second examination by a health care professional, in cases where the insured requests a reconsideration of a decision, may impose costs up to $500 per review. On average, less than 2% of the estimated 66,000 claims are denied or limited, which is approximately 1,320 claims per year. Assuming that approximately 50% of these denied claims are pursued to the point of a second review, the total cost of these reviews, using the $500 fee estimate, would be an added $330,000 to PIP claims costs. This total fee spread over all of the PIP claims and policies held in the state (approximately 1.5 million) would be approximately $5.00 per claim filed or $0.22 per PIP policyholder per year. The Commissioner does not believe that these costs are excessive; however, after fully considering the comments and other practical problems of implementing this review, the Commissioner decided to withdraw this item for the time being (see Appendix A).

Specific Cost Factors and Special Cases

(1) Reviewing Panels

Insurer representatives raised concerns during the hearing held February 26, 1997, that costs of IMEs and other peer review procedures would be greatly increased by the proposed restrictions on the types of reviewing professionals because frequently claimants are treated by multiple health care professionals at the same time. By requiring reviewers to be licensed in the same health care field as the treating professional, an insurer may have to use multiple professionals to review one case, thus significantly increasing claims costs. Although insurers currently use a variety of reviewing professionals from all types of health care professions, in cases where multiple providers are treating the claimant they do not always review each type of treatment using professionals in the same field. Sometimes a primary diagnosing provider may oversee the care of other health care professionals. Insurer representatives providing testimony urged the Commissioner to address this issue of multiple treatment by multiple providers when considering modifications to the proposed rule.

Several comments from insurer representatives addressed concerns regarding the requirement to reconsider an IME upon request of the claimant and to provide a second opinion at the insurer's expense, especially in cases involving multiple providers. Insurer representatives

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[7] Estimation based on Fast Track Monitoring System data for 1995 compiled by NAII researchers.

point out that sometimes multiple providers may be treating a claimant. A second opinion for someone being treated by four health care professionals at $500 per IME may cost the insurer up to $2,000. Because an insured would have nothing to lose (financially) by requesting a reconsideration, insurers are concerned that this requirement may be used as a method to prevent utilization review by insurers, particularly in cases where fraud or excessive claiming is suspected. Suppose, for example, an insured requests a reconsideration of an IME reviewing the treatment of two health care professionals. Suppose the original IME reveals that excessive claiming is occurring and could result in claim abuses up to $900. The insurer now has information indicating that the company could potentially lose $900 in fraudulent claims from this case; however, in order to pursue the case it must provide additional IMEs (at $500/IME) that may result in a $1000 charge. The insurer has a disincentive to investigate this case, despite evidence of fraud, because the costs of combating fraud exceed the amount of the claim presented. If reconsiderations are used in this manner, they could add significant costs to PIP claims and possibly hamper efforts by insurers to combat fraud.

(2) Fraud

All of the insurer representatives providing testimony at the hearing held on February 26, 1997, commented on the potential effect this proposed rule may have on their ability to combat fraud. Several representatives of the insurance industry testified that, in some cases, health care professionals are not comfortable reviewing the professional treatment of colleagues in the same exact field, in the same town, for social and professional reasons. There was also testimony presented by the insurers at the hearing that reviewing the treatment of health care professionals in the same field may sometimes jeopardize the safety of the reviewer if the reviewer's diagnosis differs from the treating professional. The possible impacts that additional IME restrictions may have on the efforts to combat fraud must be considered.

Fraudulent claims appear to increase the total cost of claims significantly. A recent study cited in the Journal of Commerce[8] estimates that fraud adds 10% to the cost of the average property and casualty insurance policy. A study by the RAND Institute[9] concludes that if premiums vary in proportion to compensation costs of excessive (fraudulent) claims in Washington state, roughly $125-145 would be added to the premium charge of each policy per year. The Insurance Research Council concludes that excessive claims represent between 17% and 20% of total injury claim payments.[10] In general, it appears that fraud, most commonly seen in the form of excessive medical charges, adds significantly to the cost of PIP claims.

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[8]Page 1 of September 9, 1996 edition.

[9]A. Carroll, A. Abrahamse, M. Vaiana, The Costs of Excess Medical Claims for Automobile Personal Injuries, RAND Institute, 1995.

[10]Fraud and Buildup in Auto Injury Claims, IRC, 1996.

Sidney Snyder, Jr., an attorney representing Farmers Insurance, provided an example of one case of fraud where the treating doctor routinely used four different types of diagnostic tests, ranging in price from $100 - $1,200 each. A significant number of these tests were eventually deemed unreasonable in a court ruling. Farmers Insurance was unable to find any local health care professionals in this doctor's field who would testify against this doctor because they did not want to damage their own professional relationship with him. Some providers refused to get involved because the doctor in question had filed and threatened lawsuits against other doctors who had expressed opinions contrary to his regarding the use of these diagnostic tests. Farmers eventually employed an out-of-state doctor in the same field as the treating doctor to perform the review.

If the proposed rule requirements regarding IME policies increase the cost of fighting fraud or reduce the ability of the insurers to fight fraud, as these insurer representatives fear it would, insurers can be expected to pass along this cost to policyholders in the form of higher insurance rates. All of the examples provided by insurers are related to cases where multiple providers are treating the insured or where local, in-state reviewers are either not available or willing to review their peers. These potential costs have been mitigated, in part, by changing the rule to allow out-of-state reviewers to review treatment when necessary[11]. These costs could be further lessened by focusing on the mitigation of IME reviews in cases where multiple health care professionals treat the insured.

Probable Benefits of IME Requirements

Peer reviews and IMEs are ideally used by insurers as a tool to: (1) Ensure that persons covered by PIP are receiving appropriate coverage; (2) to deny and limit coverage in excess of the insurer's contractual obligation; and (3) to investigate cases where fraud is suspected.

Part of the intent of this proposed rule is to prevent insurers from using IMEs and other peer review practices to limit PIP coverage and preclude the insured from receiving the reasonable amount of treatment to which they are contractually entitled. The intended benefits of professionals in the same specialty performing reviews and offering reconsiderations of reviews would be to ensure that all such reviews are performed fairly. This issue is explored in #2 below. On the other hand, some insurers claim that it is sometimes useful to perform peer reviews using professionals in different fields that typically manage the condition under consideration in order to ensure that persons covered by PIP are receiving appropriate treatment. This issue is covered in #1 below.

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[11] See Small Business Economic Impact Statement, 1997 and Appendix A.

(1) Checks and Balances – Possible Reduction in PIP Benefits

Some insurers claim that restricting the reviews of health care professionals to persons in the same exact license category may actually reduce potential benefits of the PIP coverage. Janine Santos of SAFECO claims that 50% of the IME reports recommend either a better course of treatment or advise continuing the same course of treatment. Some of the insurers claim that this "better course of treatment" recommendation generally comes from a reviewer who is not in the same field as the treating physician and can prove to be beneficial to the insured.

Barbara Kendall, from Mutual of Enumclaw, states that her company will often use neurologists to review any treatment of conditions involving numbness of limbs, regardless of the field specialty of the treating provider, in order to either rule out or appropriately treat conditions related to nerve damage which might only be detected through specialized exams such as MRIs. Mike Kapphahn, from Farmers Insurance, testified at both rule-making hearings that cross-disciplinary reviews may often prove very beneficial to the insured. He cited one case where a Farmers policyholder had received long-term care from a naturapathic physician for pain. Mr. Kappahn says this person eventually died from cancer that may have been easily detected with the use of X-rays rendered by a radiologist or other health care professional qualified to perform X-rays.

(2) Improving the Fairness of the Review Process

To assess the potential benefits of the requirement that reviewing health care professionals be in the same health care license as the treating professional, I use OIC complaint data. The Insurance Commissioner most likely does not receive all of the complaints insured persons may have regarding their PIP coverage; however, the data indicate where some of the more prevalent problems arising from PIP claims may occur. To assess the potential benefits of changing the requirement, one must first determine whether or not insureds perceive peer reviews or IMEs by health care professionals who have a license that is different from that of their treating professional to be a problem. In other words: Are the consumers filing complaints regarding this issue?

In an attempt to answer this question, I analyze 107 complaints received by the OIC between the April, 1995 and April, 1996. It appears that 25 of the 107 complaints filed during this time period, or 23% of the sample complaints reviewed, are clearly IME-related complaints (again, IME-related complaints appear to make up a disproportionate share of complaints relative to small number of claimants (less than 2%) that actually receive IMEs). Although 23% of the complaints mention the use of IMEs, only two (see Figure 2) of these complaints specifically mention the use of a health care professional from a field that differed from the treating provider[12].

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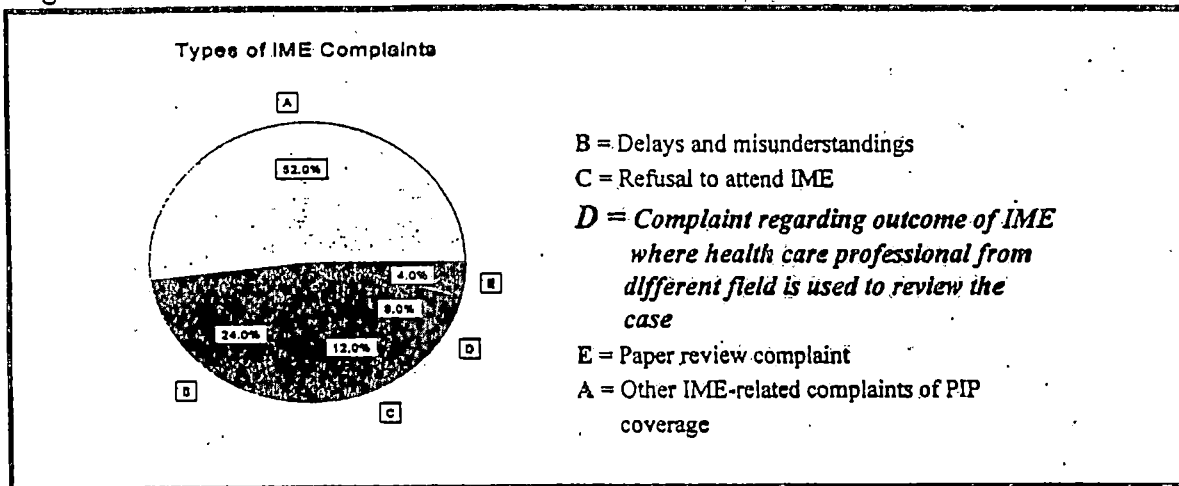
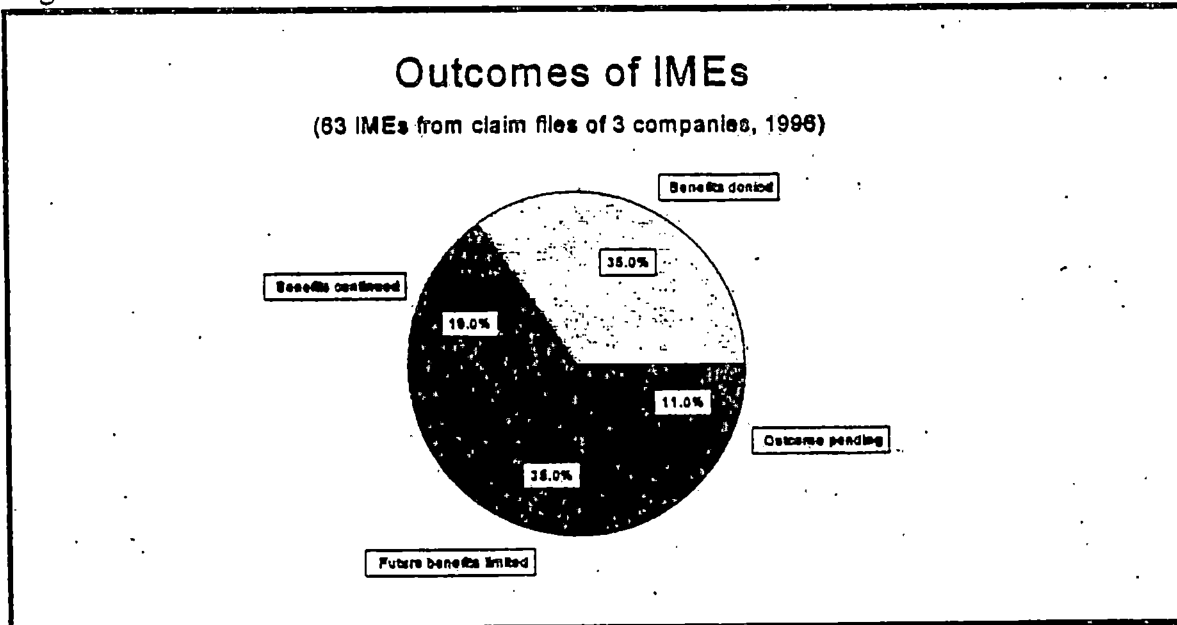
[12]It is possible that more than two of these cases involved IME professionals in fields different from the treating professional. If this issue was not specifically addressed in the complaint summary, it was not included.

Figure 2



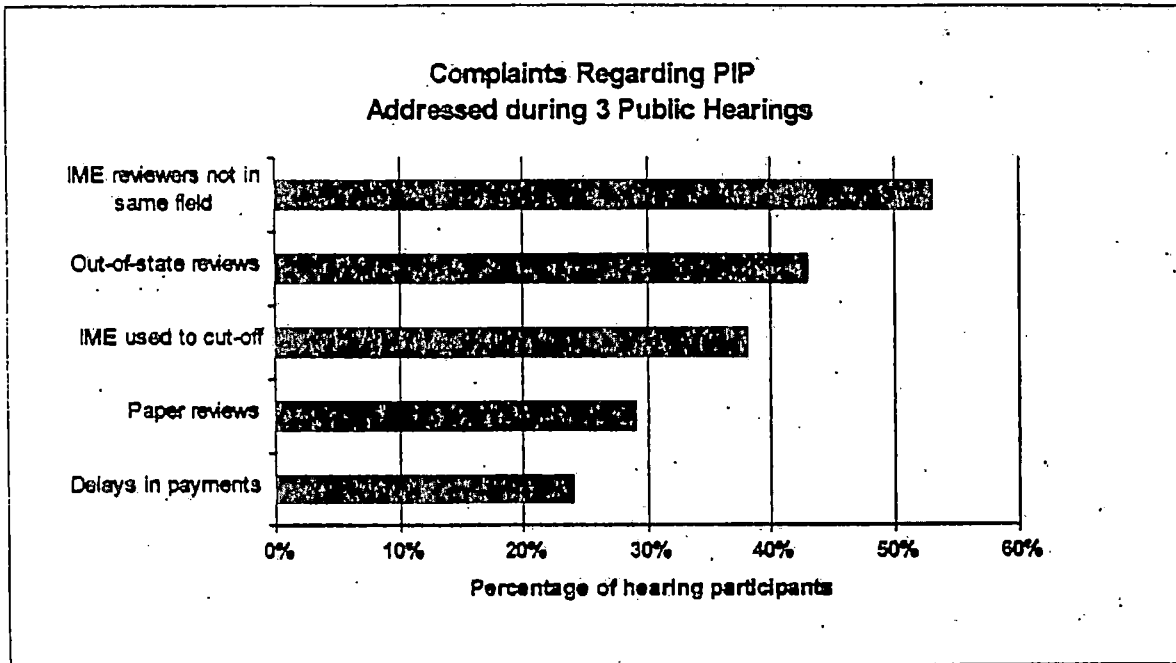
Results from data compilations collected from three of the major auto insurers in the state are also in line with OIC database estimations. The data show that of the 3 insurers observed, claim reimbursements are stopped after an IME in approximately 35% of the cases, claim reimbursements are limited after IMEs for additional 35% of the cases and claim reimbursements continue after IMEs for approximately 19% of the cases (see Figure 3). Only a small percentage of the total number of PIP claims processed would be settled in a manner (i.e. limiting medical benefits) such that an insured could be potentially dissatisfied with the type of IME reviewer she encounters.

Figure 3



Although only a small portion of total PIP claims (≈2%) are reviewed with IMEs, complaints related to IMEs and other peer review activities make up over 40% of the complaints regarding PIP coverage [13]. In three OIC Public Hearings held in Seattle, Spokane and Everett[14], over 50% of the participants providing testimony regarding PIP coverage mention concerns regarding the reviewing health care professionals that perform the IMEs (see Figure 4). The hearing participants strongly recommended that only health care professionals licensed in the same field as the treating professional should be allowed to perform peer reviews for the sake of fairness. Many of these participants point to the Chiropractic Quality Assurance Commission policy that only chiropractors are qualified to review the work of other chiropractors.

Figure 4



(3) Benefits of Reconsideration

The requirement that claimants may request a reconsideration of IME and peer review decisions is intended to insure fair evaluations by independent medical examiners. Many consumers, attorneys that represent consumers, and treating health care professionals testified at public hearings stating their belief that independent medical examiners are not necessarily always "independent," and

[13]Calculated from 177 complaints filed with three of the largest auto-insurers in the market in 1996.
[14]Fact-finding public hearings held during the winter and spring of 1996.

frequently render opinions that satisfy pre-determined objectives of insurers to cut-off benefits to the consumers. Although complaints frequently involve disagreements over the use of IMEs by insurers, a second opinion from an additional IME or other peer review does not appear to be the solution consumers are calling for. Frequently the IME-related complaints are over the usage of IMEs, in general, as a tool to limit or terminate medical benefits. Sometimes claimants are not aware that their medical records are open for review and that the patient is subject to evaluation. Many times the insured persons are upset that they have to take the time out of their schedules to be reviewed in the first place. A second trip to a reviewer's office would not solve any of these problems. In addition, as mentioned in the previous section, this requirement may have unintended consequences that would drive up the cost of claims, making it a less than cost-effective solution to the problems.

PART III
Consideration of Policies and Rules of Other State Agencies

Scope of Licenses of Health Care Professionals
The licenses of some health care professionals, issued by the Department of Health, are limited so that they may not be able to diagnose or prescribe certain treatments. For example, RCW 18.108.010(2) specifically prohibits a massage therapist from diagnosing treatment to patients receiving insurance money in a PIP settlement. Many of these types of therapists, however, commonly review the treatment of other therapists in their field and evaluate the effectiveness of treatments (but do not review the diagnosis). Careful attention should be paid to the language of the proposed rule, so that the rule does not require these professionals to exceed the scope of their professional licenses. One method for dealing with this issue would be to modify the language in the proposed rule so that it specifically refers to the "primary diagnosing or prescribing" health care professional who is treating the claimant instead of simply referring to the treating health care professional.

Labor & Industry Policies
The Department of Labor and Industry regulates worker's compensation. The Department of Labor and Industry has regulations in place (Chapter 296-23 WAC) relating to the types of medical professionals that can perform IMEs for worker's compensations cases. The Labor and Industry rules focus on an "impairment rating" approach that allow a reviewing professional to review the condition rather than focus solely on the treatment of a claimant; thus, the reviewing professional could be from the same field or from a field that commonly treats the condition in question. A medical professional that possesses a license with a relatively broad scope may be able to review the work of medical professionals with more limited licenses. The portion of the proposed PIP rule that requires reviewing professionals to be in the same field as the treating professional deviates from the approach Labor and Industry takes with regard to regulation of a similar matter.

Chiropractic Quality Assurance Commission (CQAC)
The Chiropractic Quality Assurance Commission functions as an independent board under the State Department of Health to develop appropriate licensing criteria for chiropractors practicing in the state of Washington. In 1994, this commission completed a report on Independent Chiropractic Evaluations which concluded that only chiropractors should be reviewing the treatment of other chiropractors. The results of this report lead to a policy enunciated by the CQAC guiding the review of chiropractic treatment. This policy has not been adopted as a Department of Health rule.

PART IV

Conclusions and Recommendations

The following summarizes the primary conclusions and recommendations of the cost-benefit evaluation process. The italicized sections describe the response and changes made to the rule in an effort to minimize the compliance costs of this rule while maintaining the beneficial features.

DISCLOSURE

Recommendation
It appears that improved or additional disclosure requirements would be beneficial to insured persons and should not impose significant costs on the insurers. Letters explaining that payment of benefits may be subject to limitation or termination based on an evaluation of the claimant's medical records and treatment by independent health care consultants may clear up many of the misunderstandings that seem to result in complaints regarding termination or limitation of reimbursement of PIP claims and the use of Independent Medical Exams. Also, claim denial letters that state the specific rationale for denial in language the layperson can understand would help to improve communication and clear up misunderstandings that may arise between an insured and insurer.

Response to Recommendation
After considering all comments and cost and benefit information related to disclosure, the final draft of the proposed rule emphasizes forms of disclosure. Adequate disclosure of policy provisions and limitations at the time of a claim are important consumer protections. Consumers could benefit from disclosure by having additional information on which to base decisions concerning medical services. Insurers could benefit from this aspect of the rule by avoiding misunderstandings and potential complaints from policyholders that often arise because policyholders are not aware of the policy limitations and reasons for coverage denials. This portion of the rule appears to produce probable benefits while imposing only negligible costs (see Cost Minimization Process, attached as Appendix A). One goal of this rule is to reduce litigation which is the result of incomplete disclosure or misunderstandings between the insured and the insurer.

PEER REVIEWS AND IME RECONSIDERATIONS

Recommendation
The requirement that insurers automatically provide second opinions of peer reviews or IMEs upon request may not be a cost effective solution to resolve the types of complaints present in the market. Complaints filed with the OIC indicate that insured persons generally prefer not to take the time out of their schedules to attend additional medical reviews in which little new information results. This requirement may also provide a disincentive for insurers to thoroughly investigate cases that potentially involve fraud. Thus, it appears that this requirement could be eliminated, reducing costs without significantly reducing potential benefits of this rule.

Response to Recommendation
Because this process seems to offer no substantial qualitative or quantitative benefits and due to the potential of significant costs that might be imposed on insurers by requiring reconsiderations, this portion of the rule was eliminated. The potential costs on insurers considered include additional IME fees and possibly increased difficulties in reviewing fraudulent claims. These costs have now been reduced to zero. Complaints of this nature will be considered and reviewed in the future to assess the potential need to introduce this type of requirement.

IME AND PEER REVIEW REQUIREMENTS

REDUCING PROBABLE COSTS

Recommendation
To deal with the potential costs of multiple reviews in cases where there are multiple treating providers, the language of the rule could be modified, keeping in mind that in many cases where multiple health care professionals are treating the insured, it is likely that one of the professionals is "in charge" of the plan of treatment. One method for dealing with this issue would be to modify the language in the proposed rule so that it specifically refers to the "primary diagnosing or prescribing" health care professional instead of requiring reviews of every treating health care professional. This would also clear up any potential problems that might arise in reviewing cases where a health practitioner's license does not allow the licensee to diagnose or prescribe treatment. This type of change would also preserve the benefits of the proposed rule (improving fairness of IME and peer reviews) while reducing probable costs to a negligible amount.

Response to Recommendation
Because all examples of the potential costs of this rule involved cases where the policyholder is being treated by multiple providers, this portion of the rule was modified to mitigate these costs by requiring that the "primary diagnosing" health care professional be required to review cases (where multiple professionals are utilized). It is likely that one of the professionals in a multi-treatment situation is the primary provider and in charge of the plan of treatment. Because the potential benefits of this requirement come in the form of improved fairness of the review by requiring reviews to be performed by health care professionals in the same field as the treating professional, the rule maintains this requirement. These modifications to the new subsection (3), however, allow a certain amount of flexibility in the review process so that potential costs are reduced to a minimal level. Because insurers already employ all types of health care professionals to perform utilization reviews, there are no explicit costs imposed on insurers by including this requirement in the rule.

INCREASING PROBABLE BENEFITS

Recommendation
To address the concern of the insurers that potential benefits from cross-disciplinary reviews may be lessened by the proposed peer review standards, the language could be modified so that these types of reviews are not prohibited. For example, if the insurer would like to review a case where a chiropractor is treating an insured whose symptoms include numbness of a limb, the insurer must review the work of the chiropractor with a professional review that utilizes a chiropractor; however, the insurer should not be prohibited from providing an additional professional review that employs the use of a neurologist if the insurer feels it is necessary and potentially beneficial to the insured to do so.

Response to Recommendation
The new subsection (3) of the rule includes this alteration. This modification provides more flexibility in handling claims while preserving features of the rule that protect consumers and provide standards for fair and equitable claim settlements.

Appendix A

Cost Minimization Process

Preliminary Drafts		Rule as Adopted
General Disclosure		
In previous drafts of this rule, insurers were required to mail and maintain proof of letters notifying policyholders of the insurer's right to deny medical benefits upon review.		Because an estimated 95% of all insurers already provide written procedures when mailing claim forms, this requirement was modified to reflect the current practices of insurers such that, at the most, only a one sentence amendment to current form letters might be required by this rule.
Cost estimated by Insurers: • The cost would be over $1.00 per claim.	Cost Reduction →→→→	Cost estimated by Insurers: • For an estimated[1] 95% of insurers, the cost would be negligible (simply amending or modifying current cover letter). For the remaining 5%, the cost would be approximately $0.40 per claim to draft, print, and mail a cover letter with required language.
Peer Review Disclosure		
Previous drafts of this rule included requirements that health care professionals, on which the insurance company relies for medical reviews of claims, must complete a questionnaire detailing their type of practice upon request.		Because of the difficulties specified by insurers, this rule was modified such that no questionnaire (to be completed by health care professionals) is required.
Cost estimated by Insurers: • Difficulties would exist in forcing health care professionals to complete this type of questionnaire.	Cost Reduction →→→→	Cost estimated by Insurers: • Insurers will not be required to complete a provider questionnaire. Potential cost impacts are reduced to zero.
Peer Reviews		
Previous drafts included requirements that reviewing health care professionals be licensed in the state of Washington.		The rule no longer requires that these health care professionals be licensed exclusively in the state of Washington.
Cost estimated by Insurers: • In some cases, a professional licensed in the state of Washington may not be available or convenient for a given situation and might potentially impose travel costs on either the health care professional or policyholder. Also, in some cases, a local professional may not feel comfortable reviewing a peer. In some fraud cases, insurers claim it may be necessary to seek professionals outside of the state.	Cost Reduction →→→→	Cost estimated by Insurers: • Insurers will be allowed the flexibility to utilize out-of-state health care reviewers which may be more appropriate and less costly in border regions and in special situations where the policyholder seeks out-of-state health care. This also addresses insurers' concerns regarding increasing costs of fighting fraudulent cases where local professionals are not willing to testify against their peers. Potential travel and search cots are eliminated.

[1] estimation based on a phone survey, sampling 10% of the insurers affected by proposed rule

Cost Minimization Process (Continued)

Peer Reviews		
Previous drafts required peer review professionals to be licensed in the same specialty as the treating professional, regardless of how many professionals may be treating the insured.		In cases where the insured is being treated by multiple health care professionals, the rule now requires IME and peer reviews to be conducted by the primary diagnosing health care professional only.
Cost estimated by Insurers: • Insurers were concerned that treatments might be prescribed by one type of professionals but performed by other professionals. The rule would require each type of treatment to be reviewed by a professional with the same license as the treating professional. In the case of an insured who is treated by 4 health care professionals (but under the diagnosis of one professional), this could increase the cost of an IME from $500 to $2000. Insurers claimed that this was not an uncommon occurrence (no specific data provided).	Cost Reduction →→→→	**Cost estimated by Insurers:** • The rule was changed to allow more flexibility in cases where the insured is treated by multiple professionals. For example, in the case mentioned by insurers where an insured is being treated by 4 health care professionals (but under the diagnosis of one professional), the potential IME fee of $2000 is reduced down to $500. The $500 IME charge is the normal cost of doing utilization reviews, currently a standard practice in the auto insurance market. No new costs are imposed by this requirement.
Peer Review Reconsideration		
Previous drafts of the rule required insurers to grant a second peer evaluation to insured persons upon request, at the insurer's expense.		The rule no longer requires that peer review reconsiderations be granted to policyholders upon request.
Cost estimated by Insurers: Fees for reconsiderations of IMEs are estimated to be approximately $500 per IME. Insurers were also concerned that this might be used as a tool by persons involved in fraudulent claims to avoid denials by driving up the costs of utilization reviews.	Cost Reduction →→→→	**Cost estimated by Insurers:** This has been eliminated, reducing the cost of compliance to zero.

RULE-MAKING IMPLEMENTATION PLAN
Pursuant to RCW 34.05.328(3)
Personal Injury Protection
R 96-6

To inform and educate licensees about the rule, the Commissioner will send the final version of the rule to all insurers and make the rule generally available on the Commissioner's Home Page on the Internet. Press releases will be sent to professional publications that are likely to be read by affected licensees. In addition, the Commissioner will provide licensees with specialized and targeted technical assistance on an "as needed" basis, particularly during the first year after adoption.

The Commissioner will monitor inquiries received from insurers and from consumers to see if the rule requires clarification, to see if patterns or special compliance problems emerge that will require additional regulatory or legislative oversight, and to determine whether the rule achieves the purpose for which it was adopted.

H:\WPDOCS\PIPAUTO\IMPLEMNT.PIP
June 4, 1997

SMALL BUSINESS ECONOMIC IMPACT STATEMENT
Personal Injury Protection Rule
Insurance Commissioner Matter No. R 96-6

(a) **Is the rule required by federal law or federal regulation?**
No

(b) **What industry is affected by the proposed rule?**
Fire, Marine, and Casualty Insurance (#6331)

(c) **List the specific parts of the proposed rule, based on the underlying statutory authority (RCW section), which may impose a cost to businesses.**

Written Disclosure: As soon as possible 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 is required to advise an insured in writing that it reserves the right to deny medical and hospital benefits to an insured after review.

Written Notification of Claim Denials: As soon as possible after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall advise an insured in writing. The notification shall be clear and unambiguous. The insurer shall outline in writing the means by which an insured may request a prompt reconsideration or appeal of that determination.

Standards for Claim Denials: Health care professionals upon whom the insurer will rely to make a decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered in this state to practice in the same health field or specialty as the treating professional or in a health care field or specialty that typically manages the condition, procedure, or treatment under consideration.

(d) **What will be the compliance costs for industries affected?**
The following potential costs to insurers are considered:

- preparing or amending written notification to all insured persons intending to file a personal injury claim
- preparing or modifying letters notifying clients of claim denials
- contracting with appropriate health care professionals to perform medical reviews

(e) **What percentage of the industries in the four-digit standard industrial classification will be affected by the rule?**
One hundred percent of the insurers that choose to offer personal injury protection as part of automobile liability insurance policies in the state of Washington.

(f) **Will the rule impose a proportionately higher economic burden on small businesses within the four-digit classification?**
No. The rule imposes no lump sum costs or fixed costs that would disproportionately affect smaller businesses. All potential costs of this rule are marginal costs per claim by policy holder; thus, potential costs would be in direct proportion to the volume of claims filed. The cost of compliance per employee may vary on a company-by-company basis; however, this variance is based on the extent to which the company already meets the new standards and not on the size of the insurer.

(g) **Can mitigation be used to reduce the economic impact of the rule on small businesses and still meet the stated objective of the statutes which are the basis of the proposed rule?**
Potential costs of compliance have been reduced to a negligible amount (see (i) for more detail). Note the potential costs considered in this evaluation:

1. **preparing or amending written notification to all insured persons intending to file a personal injury claim**
⇒ The potential costs of this rule have been reduced to the negligible cost of merely modifying already existing cover letters sent with claim forms for an estimated 95% of the insurers. The remaining 5% of insurers that may not be sending cover letters shall be required to provide written notification with appropriate language. See (i) for specific cost information.
2. **preparing or modifying letters notifying clients of claim denials**
⇒ It is the practice of all insurers to send written notification of the a claim denial[1]. Thus, this rule does not impose any significant additional administrative costs.
3. **contracting with appropriate health care professionals to perform medical reviews**
⇒ Insurers already utilize health care professionals to review medical claims[2]. This rule does not force insurers to contract with new or additional professionals. It merely requires the health care professional be certified in a field or specialty that typically manages the condition, procedure, or treatment under consideration. See (i) for specific cost information.

Any further mitigation would prevent the rule from meeting the objective of providing standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance.

(h) **What steps will the Commissioner take to reduce the costs of the rule on small businesses?**
Concerns were raised with regards to the professional qualifications of the reviewing health care professionals. A rule requiring the health care reviewer to be licensed in an "identical" field as the treating professional may potentially be more binding on smaller insurers than on larger insurers. For example, a smaller insurer may not have as large of a pool of health care professionals from which to choose as a larger insurer. This concern was addressed by requiring the reviewing health care professional to be licensed either in the same field OR "in a

[1] This conclusion is based on interviews, a survey, and comments solicited from the insurers.
[2] This conclusion is based on interviews, a survey, and comments solicited from the insurers.

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health care field or specialty that typically manages the condition, procedure, or treatment under consideration."

(i) **Which mitigation techniques have been considered and incorporated into the proposed rule?**

Consideration of cost mitigation has occurred throughout the rule drafting process. With regards to the specified cost implications in (c), potential recordkeeping and administrative costs have been reduced in the following manner:

Preliminary Drafts		Draft proposal upon filing of CR-102
In previous draft rule, insurers were required to mail and maintain proof of letters notifying policyholders of the insurer's right to deny medical benefits upon review		Because an estimated 95% of all insurers already provide written procedures when mailing claim forms, this requirement was modified to comply as much as possible with insurers current practice such that, at the most, only a one sentence amendment to current form letters would be required by this rule.
Cost estimated by Insurers: >$1.00 per claim	Cost Reduction →→→→	**Cost estimated by Insurers:** For an estimated[3] 95% of insurers, the cost would be negligible (simply amending or modifying current cover letter). For the remaining 5%, the cost would be approximately $0.40 per claim to draft, print, and mail a cover letter with required language.
Previous drafts included requirements that the health care professionals on which the insurance company relies for medical reviews of claims must complete a questionnaire detailing their type of practice upon request. Also, previous drafts also considered requirements that reviewing health care professionals be licensed in the same specialty as the treating professional.		Because of the difficulties specified by insurers, this rule was modified such that no questionnaire (to be completed by health care professionals) be required. Also, the rule allows for reviewing health care professionals to be licensed, registered, or certified in the same field as the treating professional OR a field that typically manages the condition, procedure, or treatment under consideration.
Cost estimated by Insurers: Difficulties would exist in forcing health care professionals to complete said form. Also, in some cases, a professional in the identical specialty as the treating professional may not be available and may impose travel costs on either the professional or policyholder.	Cost Reduction →→→→	**Cost estimated by Insurers:** All insurers currently use health care professionals to perform medical reviews of claims; thus, there is no potential cost imposed by this rule. In the event that insurers are NOT using professionals in the same or similar field as the treating health care professional, this rule would merely require insurers to change the type of professional they utilize. The rule would NOT require additional professional services.

[3] estimation based on a phone survey, sampling 10% of the insurers affected by proposed rule

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(j) **Which mitigation techniques were considered for incorporation into the proposed rule but were rejected, and why?**

The comments from insurers regarding his rule include recommendations to withdraw the proposed rule, insisting that no rule is necessary because other claims settlement practice rules already apply. Although insurers feel they are already settling personal injury protection claims in a fair manner, the number of complaints and inquiries the Commissioner's office receives regarding this matter indicates there are problems with the current settlement process. The Commissioner's office logged over 700 complaints and inquiries in the past four years regarding personal injury protection matters. This rule is designed to address these complaints.

The Commissioner also considered eliminating the requirement that health care professionals reviewing the claims be registered, licensed, or certified in the state due to complications arising in border areas such as Vancouver. This form of mitigation was considered and rejected at this time.

(k) **Briefly describe the reporting, record keeping, and other compliance requirements of the proposed rule.**

Insurers will have to maintain information in an insured's claims file such as copies of letters of denials to policyholders and proof of certification of the reviewing health care professional. This should not result in any significant costs.

(l) **List the kinds of professional services that a small business is likely to need in order to comply with the reporting, record keeping, and other compliance requirements of the proposed rule.**

Small businesses are not likely to need any new or additional professional services to comply with these rule.

(m) **Analyze the cost of compliance including, specifically:**

- Cost of equipment: No new equipment will be required
- Cost of supplies: No new supplies will be required; however, in the event the insurers are not already sending cover letters with claim forms to policyholders upon notification of an accident, the cost of one additional sheet of paper per claim may be imposed.
- Cost of labor: The employees of the insurer may be required to modify or amend the insurer's cover letter included with the mailing of claim forms and claim denial reports.
- Cost of increased administration: No new administrative costs are anticipated.

(n) **Compare the cost of compliance for small business with the cost of compliance for the largest businesses in the same four-digit classification, using one or more of the following [as specifically required by RCW 19.85.040(1)(a), (b), and (c)].**

The number of employees hired by companies varies proportionately with the number of policyholders and volume of claims. Because the only potential costs imposed by these rule are marginal costs per claim, the costs of compliance per employee for small insurers should be no greater than the costs per employee for large insurers. The cost of compliance per employee may vary on a company-by-company basis; however, this variance is not based on the size of the insurer (measured in terms of employees, hours of labor, and sales volume), but rather on the extent to which the company already meets the new standards. In a phone survey, sampling over 10% of the insurers of varying size, no relationship was found between the size of the firm and the extent to which the company already meets the new standards; thus, the per employee cost should not be substantially different between the largest and the smallest insurance insurers in this business.

(o) **Have businesses that will be affected been asked what the economic impact will be?**

Yes. On August 14, 1996, a meeting was held to discuss possible rule regarding utilization review standards in personal injury protection coverage where all affected parties were invited to attend.. From August 12th through October 17th, comments from affected parties regarding current drafts of proposed rule were solicited and reviewed by staff. These comments included information on specific cost implications of the rule. On October 14, 1996, a second work group meeting was held to discuss the fourth draft of the proposed rule.

In addition, a phone survey was conducted, sampling over 10% of the affected insurance insurers of various sizes to determine the potential costs of the proposed rule.

(p) **How did the Commissioner involve small businesses in the development of the proposed rule?**

The Commissioner contacted a number of insurers that volunteered to assist in the development of the rule, the accurate assessment of the costs of the proposed rule, and the means to reduce the costs imposed on small insurers and agents. The insurers that participated ranged from large to small, and included the associations that represent a vast majority of the property/casualty insurers engaged in the transactions of insurance in this state.

In addition, a phone survey was conducted, sampling over 10% of the affected insurance insurers of various sizes to determine the potential costs of the proposed rule. This survey intentionally included samples from the both the largest and smallest affected insurers in the industry.

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(q) How and when were affected small businesses advised of the proposed rule?

See (o) and (p) above.

In addition, a copy of the proposed rule will be sent to the Association of Washington Businesses and to the Independent Business Association. Insurers known to be interested in this rule regardless of size, were directly involved.

Conclusion

The Commissioner has the responsibility of protecting consumers against unfair practices in the insurance industry. The objective to protect the consumer has guided the drafting of this rule. While the Regulatory Fairness Act requires the Commissioner to involve small licensees in the rule making, the Commissioner recognizes that this rule also impacts the health care providers who provide services to insureds. The Commissioner also recognizes that many of these providers are an important part of the small business community. This rule was developed after review of the Commissioner's complaints data base and after health care providers and attorneys that represent insureds asked the Commissioner to provide some protection against the unfair claims settlement practices of insurers. Commissioner representatives met with providers and consumers representatives, as well as insurers during the drafting process of this rule.

18

APPENDIX D

American Family Mutual Ins Co	Year		Direct Premiums Earned -Received-		Direct Losses Incurred -Paid-		Difference
American Family Mutual Ins Co	2013	$	183,172,000.00	$	132,098,000.00	$	51,074,000.00
American Family Mutual Ins Co	2014	$	199,843,000.00	$	150,050,000.00	$	49,793,000.00
American Family Mutual Ins Co	2015	$	208,582,000.00	$	151,542,000.00	$	57,040,000.00
American Family Mutual Ins Co	2016	$	192,646,000.00	$	141,910,000.00	$	50,736,000.00
American Family Mutual Ins Co	2017	$	166,389,000.00	$	114,678,000.00	$	51,711,000.00
TOTALS		**$**	**950,632,000**	**$**	**690,278,000**	**$**	**260,354,000**

APPENDIX E

STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION

IN THE MATTER OF:	)	
	)	
UNITED SERVICES AUTOMOBILE ASSOCIATION (USAA) (NAIC # 25941)	)	DOCKET NO. 17-010-I
	)	
USAA CASUALTY INSURANCE COMPANY (NAIC # 25968)	)	
	)	
USAA GENERAL INDEMNITY COMPANY (NAIC # 18600)	)	
	)	
GARRISON PROPERTY AND CASUALTY INSURANCE COMPANY (NAIC # 21253)	)	

STIPULATION AND CONSENT ORDER

The Insurance Division of the Vermont Department of Financial Regulation ("Department") and United Services Automobile Association (USAA), USAA Casualty Insurance Company, USAA General Indemnity Company, and Garrison Property and Casualty Insurance Company (collectively "Respondents") stipulate and agree:

1. Pursuant to authority contained in 8 V.S.A. §§ 11, 12, 13, 15, 4723, 4726, and Chapters 101, 129 and 131, the Commissioner of the Department ("Commissioner") is charged with enforcing the insurance laws of the State of Vermont.

2. Pursuant to the authority contained in 8 V.S.A. § 4726, the Commissioner may examine and investigate any person engaged in the business of insurance in Vermont in order to determine whether that person is complying with Vermont insurance laws, and may suspend or revoke the license of any insurer, and/or may impose an administrative penalty for any violation of Title 8, Chapter 129.

3. Respondents are companies that are licensed to sell insurance in Vermont. Respondents' corporate headquarters is located at 9800 Fredericksburg Road, San Antonio, TX 78288.

4. The examination of USAA and its subsidiaries and affiliates (Group Code 0200), which was initiated as a result of a referral from the Department's Consumer Section, began on May 16, 2016 and covered the period from January 1, 2013 through December 31, 2015.

5. Respondents acknowledge and admit the jurisdiction of the Commissioner over the subject matter of this Stipulation and Consent Order.

FINDINGS

6. Pursuant to 8 V.S.A. § 4724(9)(F), failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonable clear constitutes unfair or deceptive acts or practices in the business of insurance in violation of 8 V.S.A. § 4723 and enforceable under 8 V.S.A. § 4726. The Department identified instances where practices were counter to the requirement to adhere to fair and equitable treatment of claimants, including:

a. accepting the initial payment recommendations made by its third-party vendor with a lack of documentation describing adjusting activities by the adjuster;
b. advising claimants to discuss services and costs with the provider before beginning treatment;
c. potentially creating balance billing problems for the claimant by reducing the amount of an auto medical bill by determining what constitutes a "reasonable fee" and only paying that amount;
d. failing to disclose the amount of a "reasonable fee" until after the treatment has been performed and the billing is submitted;
e. failing to inform insureds or providers in advance when requested, whether medical treatment is covered, leaving the claimant in the position of not knowing if the treatment is covered or how much will be paid.

7. Pursuant to 8 V.S.A. § 4724(9)(D) refusing to pay claims without conducting a reasonable investigation constitutes unfair or deceptive acts or practices in the business of insurance in violation of 8 V.S.A. § 4723 and enforceable under 8 V.S.A. § 4726. The Department finds that Respondents failed to adhere to the requirement to conduct a reasonable investigation. Examples include:

a. Accepting the third-party vendor's determination regarding medical necessity without questioning the claimant or the provider; and

b. Denying coverage without conducting a reasonable investigation.

8. Pursuant to 8 V.S.A. § 4724(9)(M), failing to promptly provide a reasonable explanation, based on applicable provisions, conditions, or exclusions in the insurance policy, for the denial of a claim constitutes unfair or deceptive acts or practices in the business of insurance in violation of 8 V.S.A. § 4723 and enforceable under 8 V.S.A. § 4726. Respondents' claims files contained no documentation or supporting evidence to show that claimants were informed of the applicable provisions, conditions, or exclusions in the insurance policy that resulted in the denial of the claim.

9. Pursuant to 8 V.S.A. § 3665(d), if an insurer fails to pay timely a claim, the insurer shall pay interest on the amount of the claim. Respondents were not aware of Vermont's late pay statute and the Department found instances where Respondents violated 8 V.S.A. § 3665(d) because they did not pay interest where payment of interest was required.

10. Pursuant to 8 V.S.A. § 13(b), persons are required to appear, to testify, or to produce papers or records for examination before the Commissioner, upon properly being ordered to do so. Respondents failed to respond in a timely way to the Department's requests for Respondents' "business rules" in violation of 8 V.S.A. § 13(b).

11. Pursuant to Regulation 99-1, claims records shall be maintained so as to show clearly the inception, handling, and disposition of each claim. Respondents failed to clearly and adequately document claims handling activities in violation of Regulation 99-1.

12. Pursuant to Regulation 79-2, if a claim has not been settled within 30 working days, the Insurer is required to send a letter informing the claimant of the reasons additional time is needed. Respondents' form failed to identify what was specifically needed to settle the claim, in violation of Regulation 79-2.

13. Pursuant to Regulation 76-1, a consumer complaint means either a written communication or an oral communication subsequently confirmed in writing, to an insurer primarily expressing a grievance. Claimants use the appeals process to express a grievance with respect to Respondents' claims settlement decisions but Respondents do not treat written appeals as consumer complaints in violation of Regulation 76-1.

14. Respondents have been made aware that the Department may proceed with an administrative action against them for the violations set forth herein and seek appropriate relief pursuant to the Department's statutory authority.

15. Respondents have agreed to enter into this Stipulation and Consent Order with the Department on the terms and conditions hereinafter set forth in lieu of proceeding with a hearing.

16. Respondents waive their right to a hearing before the Commissioner or the Commissioner's designee, and all other procedures otherwise available under Vermont law, the rules of the Department, the provisions of Chapter 25 of Title 3 regarding contested cases, or any right they may have to judicial review by any court by way of suit, appeal, or extraordinary remedy with respect to the terms of this Stipulation and Consent Order.

17. Respondents acknowledge their understanding of all terms, conditions, undertakings, and obligations contained in this Stipulation and Consent Order.

18. Respondents acknowledge that this Stipulation and Consent Order constitutes a valid order duly rendered by the Commissioner and agree to be fully bound by it. Respondents acknowledge that this Order constitutes a finding by the Commissioner that Respondents have violated the provisions of Vermont law set forth above and agree not to contest such findings. Respondents acknowledge that noncompliance with any of the terms of this Order shall constitute a violation of a lawful order of the Commissioner and shall subject Respondents to administrative action or sanctions as the Commissioner deems appropriate. Respondents further acknowledge that the Commissioner retains jurisdiction over this matter for the purpose of enforcing this Order.

19. The Department retains any rights it has to respond to and address any consumer complaint that may be made with regard to Respondents and a transaction in insurance, as defined in 8 V.S.A. § 3301. This includes the right to pursue any remedy authorized by law in response to such a consumer complaint.

20. Nothing herein shall be construed as a waiver of any private right of action any person may have against Respondents.

THE DEPARTMENT AND RESPONDENTS FURTHER STIPULATE AND AGREE:

21. Respondents shall pay an administrative penalty in the amount of $85,000 within ten (10) days of the execution of this Stipulation and Consent Order.

22. Respondents shall adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. Respondents shall include guidelines and training material which emphasize the requirement to conduct a reasonable investigation prior to making a determination. This may include interviewing and/or taking recorded statements from the claimant, the provider, and any other relevant party.

23. Respondents shall properly document all USAA claims file so each file clearly shows the inception, handling, and disposition of the claim. Respondents must document the steps taken so that an examiner can review the file and it is clear what steps the adjuster took and how the steps support the ultimate determination.

24. Where Respondents fail to pay timely a claim as required by 8 V.S.A. § 3665, Respondents shall pay interest on such claims. Respondents shall include this requirement in training material and other guidance provided to its adjusters.

25. Respondents shall provide requested information to the Department in a timely manner or be subject to the $2,000 per day penalty for failure to produce papers or records for examination pursuant to 8 V.S.A. § 13.

26. Respondents shall review its use of third party vendors to ensure that vendors performing activities requiring licensure are properly licensed *or* that activities delegated to third parties are only those that do not require licensure.

27. Respondents represent that they have voluntarily initiated the following corrective actions:

a. Respondents now reimburse either the providers' agreed amount (PPO) or the charged amount for services that are related to injuries sustained in the motor vehicle accident. Respondents agree to notify the Department regarding any change to this practice.

b. Respondents are in the process of revising communications to claimants to ensure that they are clear and comply with the law. Respondents agree to provide copies of such communications to the Department for review prior to use. This includes:

   i. Revising the thirty-day status letter required by Vermont Regulation 79-2, to clearly identify with specificity the outstanding information required by Respondents in order to complete their investigation of the claim; and

ii Revising letters sent to inform the consumer of the denial of a claim, whether in whole or in part, to provide appropriate reasons for the denial, including applicable policy provisions, conditions, or exclusions.

c. Beginning on January 12, 2017, Respondents no longer review claims for medical necessity and have discontinued the use of physician review letters. Respondents agree to notify the Department regarding any change to this practice.

d. Respondents will properly document consumer complaints in accordance with Regulation 76-1. Any appeal that expresses a grievance shall be classified as a complaint.

e. Respondents agree to document all adjuster activity in the USAA claims system even when that information is also documented in a third-party vendor system.

28. Respondents shall comply with all applicable Vermont laws, Regulation, and Bulletins.

29. The Department may continue its examination of Respondents' payment of physical damage claims since Respondents were not aware of 8 V.S.A. § 3665, which requires insurers to pay interest on claims that are not timely paid. The Department agrees that this Stipulation incorporates such investigation and that it will not seek further penalties from Respondents for violations of 8 V.S.A. § 3665. Respondents will make restitution to consumers for any additional violations of 8 V.S.A. § 3665 at the statutory rate of 12 percent.

30. Respondents hereby waive their statutory right to notice and a hearing before the Commissioner of the Department, or his designated appointee.

31. Respondents acknowledge and agree that this Stipulation and Consent Order is entered into freely and voluntarily, and that except as set forth herein, no promise was made to induce the Respondents to enter into it. Respondents acknowledge that they understand all terms and obligations in this order. Respondents acknowledge that they have consulted with their attorney in this matter and that they have reviewed this Stipulation and Consent Order and understand all terms and obligations contained herein.

32. Respondents consent to the entry of this Order and agree to be fully bound by its terms and conditions. Respondents acknowledge that noncompliance with any of the terms of this Order may constitute a separate violation of the insurance laws of the State of Vermont and may subject them to sanctions. In the event the Department alleges a violation of the terms of

this Stipulation and Consent Order, conducts any follow-up examination, and/or finds any separate violation other than those outlined in this Stipulation and Consent Order, Respondents specifically do not waive the right to an administrative hearing but instead retain that right as well as all other remedies available to Respondents.

33. The terms set forth in this Stipulation and Consent Order represents the complete agreement between the parties as to its subject matter.

34. The undersigned representative of Respondents affirms that he or she has taken all necessary steps to obtain the authority to bind Respondents to the obligations stated herein and has the authority to bind Respondents to the obligations stated herein.

UNITED SERVICES AUTOMOBILE ASSOCIATION
USAA CASUALTY INSURANCE COMPANY
USAA GENERAL INDEMNITY COMPANY
GARRISON PROPERTY AND CASUALTY INSURANCE COMPANY

By Their Duly Authorized Agent:

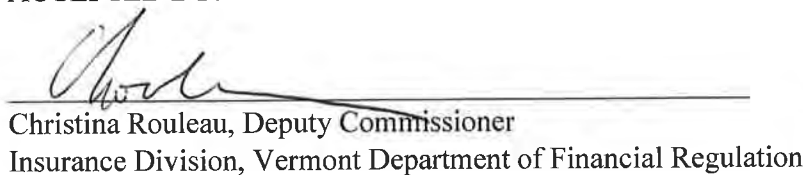
5-14-18

Signature | Date

Daniel Dilley AVP - Insurance Compliance

Printed name and title

ACCEPTED BY:



5/18/18

Christina Rouleau, Deputy Commissioner
Insurance Division, Vermont Department of Financial Regulation

Date

CONSENT ORDER

1. The stipulated facts, terms and provisions of the Stipulation are incorporated by reference herein.
2. Jurisdiction in this matter is established pursuant to Chapters 101, 129, and 131 of Title 8.
3. Pursuant to the Stipulation, Respondents consent to the entry of this Consent Order.
4. Respondents shall comply with all agreements, stipulations, and undertakings as recited above.
5. Nothing contained in this Order shall restrain or limit the Department in responding and addressing any consumer complaint about Respondents filed with the Department or shall preclude the Department from pursuing any other violation of law.

Entered at Montpelier, Vermont, this 18 day of May 2018

Michael S. Pieciak, Commissioner
Vermont Department of Financial Regulation

APPENDIX F

FILED

2010 NOV 18 AM 8:44

KING COUNTY
SUPERIOR COURT CLERK
SEATTLE, WA

JUDGE CATHERINE SHAFFER
Trial Date: October 24, 2011

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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

8

9 Dr. DAVID KERBS, individually and on behalf of the class of similarly situated persons and entities, Plaintiffs, vs. SAFECO INSURANCE COMPANY OF ILLINOIS, INC. and SAFECO OF AMERICA INSURANCE COMPANY (a/k/a "SAFECO AUTO" and/or "SAFECO OF AMERICA"), foreign insurance companies, Defendants.	No. 10-2-17373-1 SEA ORDER ON DEFENDANTS' SUMMARY JUDGMENT MOTION *(Clerk's Action Required)*

17

18 THIS MATTER having come on for hearing on November 12, 2010 before The

19 Honorable Catherine Shaffer on Defendants' Motion for Summary Judgment. The Court has

20 considered the following:

21 1. Defendants' Motion for Summary Judgment;

22 2. Declaration of John M. Silk in Support of Defendants' Motion for Summary

23 Judgment (and exhibits thereto);

WILSON SMITH COCHRAN DICKERSON
A PROFESSIONAL SERVICE CORPORATION
1700 FINANCIAL CENTER, 1215 4TH AVENUE
SEATTLE, WASHINGTON 98161-1007
TELEPHONE: (206) 623-4100 FAX: (206) 623-9273

1 3. Declaration of Elizabeth Osher in Support of Defendants' Motion for Summary
2 Judgment (and exhibits thereto);
3 4. Declaration of Yolanda Ip in Support of Defendants' Motion for Summary
4 Judgment (and exhibits thereto);
5 5. Plaintiff's Response to Defendants' Motion for Summary Judgment and Cross-
6 Motion for Partial Summary Judgment on Liability Under CR 56(c);
7 6. Declaration of David E. Breskin Re: Opposition of Plaintiff to Defendant's
8 Motion for Summary Judgment and Cross-Motion for Partial Summary Judgment (and exhibits
9 thereto);
10 7. Defendants' Reply Brief in Support of Their Motion for Summary Judgment; and
11 8. the files and pleadings herein.
12 The Court did not consider Plaintiff's Cross-Motion for Summary Judgment, as it was
13 filed and served in less time than provided for by Civil Rule 56.
14 Having heard oral argument of counsel as to Defendants' Summary Judgment Motion,
15 the Court enters the following order:
16 Now, therefore,
17 IT IS HEREBY ORDERED that:
18 1. For the reasons stated on the record on November 12, 2010, Defendants' Motion
19 for Summary Judgment is granted as to Plaintiff's claims for breach of contract and unjust
20 enrichment, which are hereby dismissed, with prejudice;
21 2. For the reasons stated on the record on November 12, 2010, Defendants' Motion
22 for Summary Judgment is denied as to Plaintiff's claim for declaratory relief and his claim under
23 the Consumer Protection Act.

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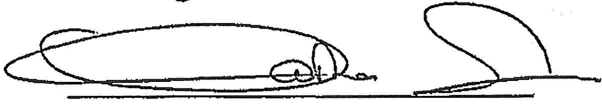
DONE IN OPEN COURT this 17 day of November, 2010.



JUDGE CATHERINE SHAFFER

Presented by:

WILSON SMITH COCHRAN DICKERSON

By *John M. Silk*
John M. Silk, WSBA# 15035
Of Attorneys for Defendants

Admitted Pro Hac Vice:
Brian E. Robison
David P. Blanke
Manuel G. Berrelez
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Honorable Theresa B. Doyle

IN THE SUPERIOR COURT FOR THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

MYSPINE, PS, a Washington professional services corporation, Plaintiff, v. USAA CASUALTY INSURANCE COMPANY, and USAA GENERAL INDEMNITY COMPANY, Defendants.	No.: 12-2-32635-5 SEA ORDER DENYING DEFENDANTS' MOTION TO DISMISS

This matter having come for hearing before the undersigned Judge on Defendants' Motion to Dismiss, and the Court having considered the following materials filed on this issue:

1. Defendants' Motion to Dismiss;
2. Plaintiff's Response to Defendants' Motion to Dismiss;
3. Declaration of David E. Breskin in Support of Plaintiff's Response to Defendants' Motion to Dismiss;
4. Defendant's Reply in Further Support of Motion to Dismiss
5. Declaration of David Scott in Support of Defendant's Reply in Further Support of Motion to Dismiss

Judge Theresa Doyle
King County Superior Court
516 Third Avenue
Seattle, WA 98104
(206) 477-1405

1 IT IS HEREBY ORDERED that:

2 In order to grant Defendant USAA's motion to dismiss under CR 12(b)(6), this Court
3 would have to find that there is no conceivable set of facts that could be shown that would entitle
4 Plaintiff MySpine to the relief requested. *Fondren v. Klickitat County*, 79 Wash. App. 850, 854
5 (1995). Defendants have not met that standard.

6 1. The Court DENIES Defendants' motion to dismiss the Plaintiff's claim under the
7 Washington Consumer protection Act, RCW 19.86, et seq. ("CPA").

8 a. MySpine may not, and does not, bring a per se CPA claim based on violations
9 of the Washington Insurance Code and/or related WACs because Plaintiff is
10 medical provider, not an insured. *Tank v. State Farm Fire & Cas. Co.*, 105
11 Wash.2d 381, 394 (1986). However, a non per se CPA claim is available to
12 MySpine because it alleges an injury to its business or property by USAA's
13 payment practices. Privity of contract or a direct business relationship with
14 the defendant is not required. *Panag v. Farmers Ins. Co. of Wash.*, 166
15 Wash.2d 27, 204 P.3d 885 (2009).

16 b. Defendant USAA next argues that MySpine's CPA claims are based on
17 personal injuries. A CPA claim is not available for a personal injury claim.
18 *Ambach v. French,* 167 Wash.2d 167, 173. However, MySpine's CPA claim
19 here is not based on personal injuries, but rather is based on USAA's practice
20 of discounting its billings under the insured's PIP coverage. Accordingly, this
21 claim can be brought under the CPA. *Williams v. Lifestyle Lift Holdings*, 175
22 Wash. App. 62, 302 P.3d 523 (2013) (botched plastic surgery procured
23 through deceptive advertising can form basis of CPA claim).

24 2. The Court DENIES Defendants' motion to dismiss the Plaintiff's breach of contract
25 claims.

26

Judge Theresa Doyle
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a. There are facts under which the plaintiff could show a valid assignment by the insured to MySpine of the right to PIP benefits under the insured's policy. Plaintiff may be an express assignee which can be shown with proof of a signed assignment. An equitable assignment of benefits under an insurance policy is created by words or conduct showing the insured's intent to assign rights to a third party. *Mercantile Ins. Co. of Am. v. Jackson*, 42 Wash.2d 233, 236 (1952). Here, the conduct of the parties—USAA directing the provider to submit bills to USAA, and USAA paying those bills directly to the provider—could show that Plaintiff is a third party beneficiary of the insurance policy if there is proof the insured intended to assign its PIP rights.

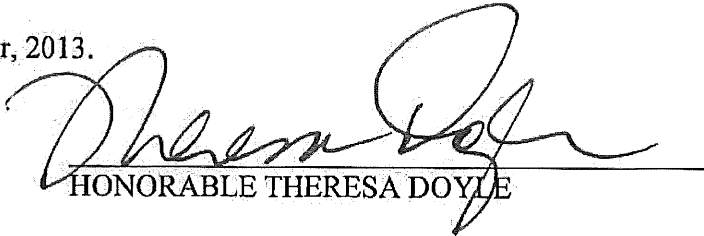
b. There are hypothetical facts which can be conceived of that would entitle Plaintiff to PIP benefits under the policies as a third party beneficiary. Required would be proof that the insured and USAAA intended, at the time of execution of the policy, that a provider such as MySpine directly benefit from the PIP coverage. The intent must be determined by the policy language and the circumstances under which it was executed. *Postelwait Construction Inc. v. Great Am. Ins. Co.*, 41 Wash. App. 763, 765 (1985). If Plaintiff can show such intent by USAA and the insured, then MySpine would have third party beneficiary status.

3. This Court DENIES dismissal on the unjust enrichment claim. The elements of unjust enrichment are: 1) a benefit conferred upon the defendant by the plaintiff; 2) knowledge by the defendant of the benefit; and 3) acceptance of the benefit by the defendant would be inequitable. *Bailie Communications Ltd. v. Trend Bus. Systems Inc.*, 61 Wash App. 151, 159-60 (1991). Here, Plaintiff could argue that USAA retained the difference between the value of the services provided and the discounted

payment, and that USAA obviously knew it was paying less than the full amounts billed. Whether it was inequitable to do so would be a question for the trier of fact.

4. The Court DENIES the motion to dismiss Plaintiff's request for a declaratory judgment. This is a remedy that could attach to one of the claims and is not a stand-alone cause of action.
5. This Court DENIES defendant's motion to dismiss on the ground that Plaintiff has not distinguished claims against USAA Casualty from those against USAA General. This claim will await discovery regarding the relationship between the defendant companies.

DATED this 21st day of October, 2013.



HONORABLE THERESA DOYLE

Judge Theresa Doyle
King County Superior Court
516 Third Avenue
Seattle, WA 98104
(206) 477-1405

APPENDIX G

RICHARD D. JOHNSON,
Court Administrator/Clerk

The Court of Appeals
of the
State of Washington

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May 16, 2011

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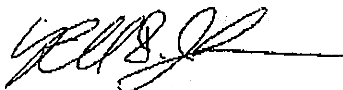
CASE #: 66905-2-I
Dr. David Kerbs, Resp. vs. Safeco Insurance, Pet.

Counsel:

Enclosed is the ruling of the Commissioner entered today in the above case.

In the event counsel wishes to object, RAP 17.7 provides for review of a ruling of the Commissioner. Please note that a "motion to modify the ruling must be served . . . and filed in the appellate court not later than 30 days after the ruling is filed."

Sincerely,



Richard D. Johnson
Court Administrator/Clerk

hek

c: Hon. Catherine Shaffer

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

Dr. DAVID KERBS, Respondent, v. SAFECO INSURANCE COMPANY of ILLINOIS, INC. and SAFECO INSURANCE COMPANY OF AMERICA, INC., Petitioner.	)	No. 66905-2-I COMMISSIONER'S RULING DENYING DISCRETIONARY REVIEW

Safeco Insurance Company seeks discretionary review of the trial court order striking Safeco's CR 12(b)(1) motion to dismiss for lack of subject matter jurisdiction and imposing sanctions of $10,000. Safeco used CR 12(b)(1) to challenge the standing of Dr. Kerbs to assert a Consumer Protection Act (CPA) claim based on the failure of Safeco to pay personal injury protection (PIP) claims to providers. It is not settled under Washington law whether a challenge to standing is the same as a lack of subject matter jurisdiction for purposes of a CR12(b)(1) motion. Therefore, Safeco does not establish it was obvious or probable error to reject its motion.

Even accepting that the trial court should have reached the merits of the standing issue, Safeco fails to demonstrate that it would have prevailed. Dr. Kerbs' relationship with his patients who have PIP coverage with Safeco, coupled with Safeco's directive that he submit his billings directly to Safeco, and Safeco's direct interaction with him regarding his billings all occurred in trade or commerce. Even though he has no direct contractual right to collect from Safeco, and apparently no valid

assignment of the insured's contract rights, the economic reality is that there may be a connection between alleged unfair and deceptive acts of Safeco and Dr. Kerbs' business or property.

Finally, the lack of any findings supporting the award of sanctions is problematic, but piecemeal appeals are not favored.

Safeco does not establish that further proceedings are rendered useless, that the status quo or freedom to act has been substantially altered, or that the trial court far departed from the ordinary course of judicial proceedings for purposes of RAP 2.3(b)(1), (2) or (3).

Therefore, discretionary review is denied.

FACTS

Dr. Kerbs is an acupuncturist who provided services to individuals who have PIP coverage with Safeco. Safeco directed the doctor to submit his billings directly to Safeco. Safeco sent his billings to a third party for analysis by means of a computer database. If Dr. Kerbs's charges exceeded the 85th percentile in the database for the service provided, then his charges above the 85th percentile were refused.

RCW 48.22.095(1) provides that PIP coverage includes "[m]edical and hospital benefits." RCW 48.22.005(7) defines "[m]edical and hospital benefits" as "reasonable and necessary expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident[.]" The Safeco policies at issue further define "reasonable and necessary expenses" as "any amount which we [Safeco] determine represents a customary charge for services in the geographic area in which service is rendered," taking into consideration "outside information of our [Safeco's] choice,

including...medical bill review services...or...[c]omputerized data bases." The Insurance Commissioner has approved the Safeco policy language.

Dr. Kerbs filed this litigation alleging that the database is skewed in favor of Safeco and that the use of the database and the arbitrary 85th percentile standard fails to meet Safeco's requirements under its PIP coverage. He alleged violations of the CPA, breach of contract and unjust enrichment. His CPA claims include both *per se* violations based on the Insurance Code and insurance regulations, and "unfair or deceptive acts or practices" theories. The trial court granted a partial summary judgment in favor of Safeco dismissing the breach of contract and unjust enrichment claims, but denied summary judgment on the CPA claims.

In that motion for summary judgment, Safeco raised arguments about the need for Dr. Kerbs to have an assignment from his patients in order to pursue any CPA claims against Safeco:

> Dr. Kerbs lacks standing to usurp the non-assignable claims the Legislature made available only for insureds, particularly given his failure to provide the written notice that is a statutory "condition precedent" to bringing such a claim.
>
> ...
>
> In short, it is incumbent on Dr. Kerbs to come forward with the assignments on which his lawsuit is based.
>
> ...
>
> It is hornbook law that an insurer is not duty-bound to a provider unless and until he or she treats an insured *and* obtains an assignment of the policy benefits for that treatment; at that point the provider is entitled only to whatever the insured was owed under the policy. [footnote omitted]

The oral argument of the summary judgment did not focus on standing or the need for an assignment, although at one point the trial court noted "I think you have standing."

The trial court also concluded that for purposes of defeating summary judgment, Dr. Kerbs provided evidence supporting the elements for a CPA claim including the requirement that the alleged deceptive acts by Safeco caused injury to him in his business or property. The trial court noted that the question before the court is whether Safeco is engaged in practices, not revealed to the Insurance Commissioner, that constitute CPA violations.

Dr. Kerbs filed an amended complaint. Safeco moved to dismiss under CR 12(b)(6) arguing that Dr. Kerbs failed to allege that his charges do not exceed the "customary charge for services in the geographic area in which the service was rendered," thus failing to plead facts establishing an injury and causation under the CPA. Safeco also argued that Dr. Kerbs has no standing to assert *per se* CPA violations of the Insurance Code and insurance regulations. The trial court denied the motion to dismiss. Safeco sought discretionary review of the CR 12(b)(6) ruling. I denied review.

After Dr. Kerbs produced two assignments he was relying upon, Safeco filed its CR 12(b)(1) motion. One assignment was limited to health insurance benefits with no reference to PIP auto insurance benefits. Another was a general assignment signed by the patient only a few weeks earlier, long after the PIP coverage had expired. Safeco argued that Dr. Kerbs' CPA claims depend upon a showing that Safeco has not complied with its contractual obligation to its insureds, but because he does not have a valid assignment of those rights from the insureds, he lacks standing to establish an injury to his business or property. Because he lacks standing, Safeco argued that the trial court lacked subject matter jurisdiction.

Dr. Kerbs moved to strike the CR12(b)(1) motion arguing that Safeco was raising the same standing arguments the trial court had already heard and resolved. On April 1, 2011, the trial court granted the motion to strike the motion and ordered that "pursuant to CR 7, CR 59(b) (time to file motion for reconsideration) and CR 11, Defendant shall pay Plaintiff in the amount of $10,000 in reasonable attorney's fees by April 8, 2011 at 4 p.m."

This court granted Safeco's emergency motion for a stay. I heard the motion for discretionary review on May 6, 2011.

CRITERIA FOR DISCRETIONARY REVIEW

Discretionary review is available only if:

> (1) The superior court has committed an obvious error which would render further proceedings useless;
> (2) The superior court has committed probable error and the decision of the superior court substantially alters the status quo or substantially limits the freedom of a party to act;
> (3) The superior court has so far departed from the accepted and usual course of judicial proceedings, or so far sanctioned such a departure by an inferior court or administrative agency, as to call for review by the appellate court; or
> (4) The superior court has certified, or that all parties to the litigation have stipulated, that the order involves a controlling question of law as to which there is substantial ground for a difference of opinion and that immediate review of the order may materially advance the ultimate termination of the litigation.

RAP 2.3(b).

Piecemeal appeals are disfavored.[1] RAP 2.3(b)(1) requires a showing of obvious error that renders further proceedings useless. An example of a decision that

[1] Minehart II v. Morning Star Boys Ranch, Inc., 156 Wn. App. 457, 467, 232 P.3d 591 (2010).

renders further proceedings useless is where the correct ruling would result in the dismissal of the entire case.[2]

RAP 2.3(b)(2) requires a showing that the status quo has been substantially altered or the freedom of a party to act has been substantially impaired. As recognized in Minehart II v. Morning Star Boys Ranch, Inc.,[3] as to the application of RAP 2.3(b)(1) and (b)(2) "[w]here there is a weaker argument for error, there must be a stronger showing of harm." Thus, under RAP 2.3(b)(1) and (b)(2) a showing of probable error requires a showing of harm that exceeds "rendering further proceedings useless." In his authoritative law review article on discretionary review, Supreme Court Commissioner Geoffrey Crooks recognizes that the Taskforce comments to RAP 2.3(b)(2) can be read as drawing a line between rulings that only impact the internal workings of a lawsuit versus rulings that have an impact external to the litigation.[4]

RAP 2.3(b)(3) involves a far departure from the ordinary and accepted course of judicial proceedings, but is limited to unusual and extreme court errors.[5]

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[2] See Douchette v. Bethel Sch. Dist. No. 403, 117 Wn.2d 805, 808–09, 818 P.2d 1362 (1991) (if the trial court had properly applied the statute of limitations, all of the claims as to all parties would have been dismissed and thus further proceedings were rendered useless).

[3] 156 Wn. App. 457, 463, 232 P.3d 591 (2010).

[4] Geoffrey Crooks, DISCRETIONARY REVIEW OF TRIAL COURT DECISIONS UNDER THE WASHINGTON RULES OF APPELLATE PROCEDURE, 61 Wash. L. Rev. 1541, 1546 (1986) ("A trial court action then arguably would not qualify for review under RAP 2.3(b)(2) if it merely altered the status of the litigation itself or limited the freedom of a party to act in the conduct of the lawsuit. An error affecting the internal workings of the lawsuit would be reviewable only if 'obvious' and, as required by RAP 2.3(b)(1), only if it truly rendered further proceedings useless.").

[5] RAP 2.3(b)(3) is limited to "the relatively unusual case calling for the exercise of revisory jurisdiction." Washington Rules of Appellate Procedure, Task Force Comment to RAP 2.3 comment (b).

DECISION

Safeco presents several arguments in support of its motion for discretionary review, but its core argument is that Dr. Kerbs' CPA claims for unfair and deceptive acts arise out of the PIP provisions of Safeco contract with its insureds. Therefore, Dr. Kerbs unfair and deceptive act CPA claims depend upon Dr. Kerbs holding a valid assignment of the insured's contract rights. Without such an assignment he cannot establish he has been injured in his business or property by virtue of the alleged unfair and deceptive acts. Therefore, he lacks standing to assert such CPA claims, and in the absence of standing the trial court lacks subject matter jurisdiction. Especially because recent discovery revealed the lack of a valid assignment, Safeco contends its CR12(b)(1) motion was not duplicative of its earlier summary judgment and CR12(b)(6) motions. Safeco concludes that the trial court erred by failing to consider the merits of its CR 12(b)(1) motion, and if considered on the merits, the CPA claims had to be dismissed for lack of subject matter jurisdiction.

Safeco does not satisfy the strict standards for discretionary review.

Standing and CR 12(b)(1). There is a preliminary question whether lack of standing is properly raised by means of a CR 12(b)(1) motion for lack of subject matter jurisdiction. The "improvident and inconsistent use of the term 'subject matter jurisdiction' has caused it to be confused with a court's authority to rule in a particular matter."[6] Subject matter jurisdiction is most fundamentally defined as "a tribunal's

[6] Shoop v Kittitas County, 108 Wn. App. 388, 394, 30 P.3d 529 (2001) (citation omitted).

authority to adjudicate the type of controversy involved in the action."[7] Subject matter jurisdiction does not depend upon the facts of an individual case.[8] The Washington Constitution includes a broad grant of general jurisdiction to the superior court.[9] In this sense, a CPA claim is the **type of controversy** the superior court has the authority to adjudicate.

"The doctrine of standing requires that a plaintiff must have a personal stake in the outcome of the case in order to bring suit."[10] This requirement has been described as "a clear legal or equitable right and a well-grounded fear of immediate invasion of that right."[11] At least in some settings, such as a challenge to the validity of a statute, standing involves an inquiry whether the interest to be asserted is in the zone of interest to be protected or regulated by the statute and whether the person asserting that

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[7] Shoop, 108 Wn. App. at 393. See also, State ex rel. LaMon v. Town of Westport, 73 Wash.2d 255, 262, 438 P.2d 200 (1968), reversed on other grounds, 103 Wn. 280, 692 P.2d 799 (1984) ("In *McDaniel*, we were improperly using the term 'jurisdiction,' for that term, in its juridical and traditional sense, refers to the abstract power of the court to hear and determine the cause. Alberta Lumber Co. v. Pioneer Lumber Co., 138 Wash. 132, 138–139, 244 Pac. 250 (1926).")

[8] Dougherty v. Dep't of Labor & Indus., 150 Wn.2d 310, 316-17, 76 P.3d 1183 (2003). See also, Custody of A.C., 165 Wn.2d 568, 573 n.3, 200 P.3d 689 (2009) (UCCJEA use of term "subject matter jurisdiction" more accurately viewed as "exclusive venue" because Washington superior court did have subject matter jurisdiction of petition for nonparental custody.); Mutual of Enumclaw Ins. Co. v. T&G Constr., Inc., 165 Wn.2d 255, 266, 199 P.3d 376 (2008) (the superior court "clearly has subject matter jurisdiction over torts as a whole." (citations omitted)).

[9] WASH. CONST. art. IV, § 6.

[10] Gustafson v. Gustafson, 47 Wn. App. 272, 276, 734 P.2d 949 (1987).

[11] DeFunis v. Odegaard, 82 Wn.2d 11, 24, 507 P.2d 1169 (1973) rev'd on other grounds, 416 U.S. 312, 94 S. Ct. 1704, 40 L. Ed. 2d 164 (1974).

interest has suffered an actual injury.[12] If a party to a CPA claim lacks standing, then the court may not grant any relief to that party, but that does not mean that the superior court lacks the general authority to adjudicate CPA claims. Safeco relies on Skagit Surveyors & Eng'rs, LLC v. Friends of Skagit County,[13] for the proposition that if a party lacks standing, then the superior court lacks subject matter jurisdiction. But Skagit Surveyors involved the prerequisites to an administrative appeal and expressly addressed "the appellate, rather than the general, jurisdiction of the superior court...Acting in its appellate capacity, the superior court is of limited statutory jurisdiction, and all statutory procedural requirements must be met before jurisdiction is properly invoked."[14] Here it is the general jurisdiction of the superior court that is challenged by the CR 12(b)(1) motion. Other Washington cases that refer to standing in terms of a lack of "jurisdiction", appear to use "jurisdiction" in a colloquial sense and do not address the precise question whether lack of standing deprives the superior court of subject matter jurisdiction.[15] Notably, in the 2008 decision in Lane v. City of

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[12] Grant County Fire Prot. Dist. No. 5 v. City of Moses Lake, 150 Wn.2d 791, 802, 83 P.3d 419 (2004) (Grant County II) (standing under Uniform Declaratory Judgment Act to challenge a statute requires first, that a party must be within the " 'zone of interests to be protected or regulated by the statute' " in question. Second, the party must have suffered an "injury in fact.").

[13] 135 Wn.2d 542, 958 P.2d 962 (1998).

[14] Skagit Surveyors, 135 Wn.2d at 555.

[15] High Tide Seafoods v. State, 106 Wn.2d 695, 702, 725 P.2d 411 (1986) (arguably dicta in the context of discussing standing to assert constitutional challenge to a statute, the court cites federal caselaw for proposition that a court lacks "jurisdiction" if party seeking relief lacks standing); Branson v. Port of Seattle, 152 Wn.2d 862, 875–76, 101 P.3d 67 (2004) (cites High Tide Seafoods but, inconsistent with established standards of subject matter jurisdiction, recites an exception that a case may be heard even if a party lacks standing, as long as the issue is one of great public interest and well briefed.)

Seattle the Washington Supreme Court recognized that the rule that lack of standing deprives the court of "jurisdiction" is in "flux".[16]

Many states recognize that standing is related to or implicit in subject matter jurisdiction, but several states recognize a distinction between standing and subject matter jurisdiction.[17]

Based on the federal "case and controversy" requirement, the majority of federal courts recognize that standing may be challenged by means of a Fed.R.Civ.P. 12(b)(1) motion.[18] But when a legislative body sets out statutory requirements for standing to

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[16] Lane v. City of Seattle, 164 Wn.2d 875, 885 n.1, 194 P.3d 977 (2008) (recites that standing is a matter of "jurisdiction" but in a footnote compares the holding in High Tide Seafoods with Branson and observes that the rule is in "flux"; "This case does not lend itself to deciding whether standing is jurisdictional in Washington, since neither party briefed the matter.")

[17] Glen Lake-Crystal River Watershed Riparians v. Glen Lake Ass'n, 264 Mich. App. 523, 695 N.W.2d 508, 528 (2004) ("'Subject-matter jurisdiction and standing are not the same thing. Jurisdiction of the subject matter is the right of the court to exercise judicial power over a class of cases, not the particular case before it; to exercise the abstract power to try a case of the kind or character of the one pending.'" Altman v. Nelson, 197 Mich. App. 467, 472, 495 N.W.2d 826 (1992)); Pulaski County Owners Imp. Dist. No. 639 v. Carriage Creek Prop., 319 Ark. 12, 888 S.W.2d 652 (1994) (standing is not a question of subject matter jurisdiction in Arkansas); Hereida v. Hereida, 203 A.D.2d 524, 611 N.Y.S.2d 236 (2d Dep't 1994) (In a wrongful death action, plaintiff's alleged lack of standing did not raise a question of subject matter jurisdiction.); LeMarin Condo. Unit Owners Ass'n, Inc. v. Bd. of Revision of Ottawa County, 176 Ohio App. 3d 342, 891 N.E.2d 1252 (2008) (Normally, "standing" refers only to the capacity of a party to bring an action, not the subject-matter jurisdiction of the court.); Direct Action for Rights and Equal. v. Gannon, 713 A.2d 218 (R.I. 1998) ("...standing is a separate and distinct legal concept from subject-matter jurisdiction."); Schill v. Wis. Rapids Sch. Dist., 327 Wis.2d 572, 786 N.W.2d 177, 188 (2010) ("Wisconsin courts evaluate standing as a matter of judicial policy rather than as a jurisdictional prerequisite."); Friedlander v. Zoning Hearing Bd. of Sayre Borough, 119 Pa. Cmwlth. 164, 546 A.2d 755 (1988) (standing issue is not jurisdictional); Statewide Bldg. Maint., Inc. v. Pa. Convention Ctr. Auth., 160 Pa. Cmwlth. 544, 635 A.2d 691 (1993) (question of standing is not an issue of subject matter jurisdiction).

[18] Article III jurisdiction for federal courts requires a "case and controversy" that federal courts read as including standing. The federal decisions recognizing that standing is properly challenged by means of a Rule 12(b)(1) motion often derive from the "case or controversy" requirement that is not present in all states. But even an occasional federal court has recognized that standing is an issue distinct from subject matter jurisdiction, because standing addresses the question whether a federal court may grant relief to a party in the plaintiff's

pursue a claim under the statute, some federal courts recognize that "statutory standing" may become intertwined with the merits.[19] At least one federal court has recognized that when a statutory standing requirement is intertwined with the merits, the question should not be resolved by means of a 12(b)(1) motion:

> In sum, despite describing the proximate causation requirement as "RICO standing," such standing is not jurisdictional in nature under Fed.R.Civ.P. 12(b)(1), but is rather an element of the merits addressed under a Fed.R.Civ.P. 12(b)(6) motion for failure to state a claim. RICO standing is sufficiently intertwined with the merits of the action, such that its determination requires an evaluation of the merits of the action and makes any potential distinction between the merits and RICO standing exceedingly artificial.[20]

I am not convinced that it is settled in Washington whether a challenge to standing necessarily goes to the subject matter jurisdiction of the court and thus is properly brought under CR 12(b)(1). Furthermore, although lack of injury is not a remarkable aspect of standing, it is arguable that a CPA claim has "statutory standing" requirements that are intertwined with the merits of the claim. In Panag v Farmers Ins.,[21] the majority rejected the proposition that standing to bring a CPA claim should be addressed as a separate requirement:

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position, whereas subject matter jurisdiction addresses the question of whether a federal court may grant relief to any plaintiff given the claim asserted. Thus objections to standing are more properly brought under a Rule 12(b)(6) motion. Vitanza v. Bd. of Trade of City of New York, No. 00-CV-7393, 2002 WL 424699 (S.D.N.Y. Mar. 18, 2002). See First Capital Asset Mgmt., Inc. v. Brickellbush, Inc., 218 F. Supp. 2d 369, 378 (S.D.N.Y.2002) (" It is unclear whether dismissal for lack of standing properly is sought under Rule 12(b)(6) or Rule 12(b)(1)..." but the difference is academic and court considered standing under Rule 12(b)(1).)

[19] In Steel Co. v. Citizens for Better Env't, 523 U.S. 83, 97 n.2, 118 S. Ct.1003, 140 L. Ed. 2d 210 (1998) (citation omitted, emphasis in original),the majority Justice Scalia noted that it can be difficult to differentiate between issues of statutory standing and the merits of a case because the two are closely intertwined.)

[20] Lerner v. Fleet Bank, N.A., 318 F.3d 113, 129–30 (2d Cir. 2003).

[21] 166 Wn.2d 27, 204 P.3d 885 (2009).

> To prevail in a private CPA claim, the plaintiff must prove (1) an unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) affecting the public interest, (4) injury to a person's business or property, and (5) causation. *Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co.*, 105 Wash.2d 778, 784, 719 P.2d 531 (1986).
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> ...
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> We decline CCS's invitation to address standing as a separate requirement. As the Court of Appeals recognized, the *Hangman Ridge* test incorporates the issue of standing, particularly the elements of public interest impact and injury.[22]

If the elements of a CPA claim, "particularly the public interest impact and injury elements," must be proven to establish "statutory standing" to bring a CPA claim, then standing is intertwined with the merits of the CPA claim. Because of this overlap, it would be extremely artificial to resolve the merits of a CPA claim in the guise of deciding standing under a CR 12(b)(1) motion. Safeco's use of a CR 12(b)(1) motion to challenge standing is in doubt.

Striking CR 12(b)(1) motion as untimely, improper or baseless. The CR 12(b)(1) motion may have been baseless in the sense that standing is not part of subject matter jurisdiction, but it appears the trial court may have been relying on Dr. Kerbs' argument that Safeco was improperly revisiting an issue the trial court had already resolved. Dr. Kerbs suggests the motion was stricken under LR 7, CR 59 and CR11 as an untimely and improper motion for reconsideration. There is some authority that a partial summary judgment can be the basis for a motion for reconsideration[23] but it is not clear that the time requirements of CR 59(b) or the limits of LR 7 apply here. A partial

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[22] Panag, 166 Wn.2d at 37–38 (citation omitted).

[23] Davies v. Holy Family Hosp., 144 Wn. App. 483, 497, 183 P.3d 283 (2008).

summary judgment remains subject to revision up until the entry of a final judgment.[24] LR 7 generally allows the trial court to cut off consideration of untimely submissions. But especially where a party gains new information in discovery related to standing, it normally would not be considered untimely, improper or baseless to ask the trial court to consider the impact of the newly discovered evidence. Here it appears that Safeco had a plausible argument that the new information on the lack of a valid and timely assignment of PIP benefits might impact the question of standing.

A trial court has broad discretion in managing motion practice before the court, and clearly a court may cut off a party from repeatedly revisiting an issue the court has already ruled on. Here it is not clear whether or not the trial court was relying on the assertion of valid assignments when it observed during the argument of the summary judgment that "I think you have standing."

To the extent that the trial court relied upon CR 11, the purpose behind CR 11 is to deter baseless filings and curb the abuses of the judicial system.[25] CR 11 authorizes the trial court to impose sanctions if a party presents pleadings, motions or memorandum that are not reasonably well grounded in fact, warranted by existing law or justified by a good faith argument for an extension, modification or reversal of existing law. Sanctions also may be imposed for filings "interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the

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[24] Absent a proper certification of finality under CR 54(b), "an order which adjudicates fewer than all claim or the rights and liabilities of fewer than all parties is subject to revision at any time before entry of final judgment as to all claims and the rights and liabilities of all parties." Washburn v. Beatt Equip. Co., 120 Wn.2d 246, 300, 840 P.2d 860 (1992); CR 54(b).

[25] Biggs v. Vail, 124 Wn.2d 193, 197, 876 P.2d 448 (1994).

cost of litigation[.]"[26] A trial court's decision to impose sanctions is reviewed for abuse of discretion.[27] In making its decision, the trial court should apply an objective standard, judging the attorney's conduct by what was reasonable to believe at the time the pleading, motion or legal memorandum was submitted.[28]

It does not seem to be baseless to argue that the recent discovery calls into question whether there were any valid assignments and the lack of assignments may impact standing. Striking the CR 12(b)(1) motion as untimely under LR 7 or CR 59(b) or as repetitive under CR 11 may be suspect, but that alone does not warrant interlocutory review.

The merits of the standing argument. Even ignoring concerns whether CR 12(b)(1) was the appropriate means to challenge a lack of standing, and accepting that the trial court should have considered the merits of the question of standing, Safeco does not establish that it would have prevailed on its updated standing argument. Notably, Safeco continues to rely upon the premise that Dr. Kerbs must hold a formal assignment of the insured's rights in order to demonstrate he has been injured in his business or property, but there is room for debate.

In Panag v Farmers Ins.,[29] the court concluded that a CPA claim can arise without any consumer or business relationship between the particular plaintiff and the actor "because 'trade or commerce' is not limited to such transaction."[30]

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[26] CR 11.

[27] Biggs v. Vail, 124 Wn.2d 193, 197, 876 P.2d 448 (1994).

[28] Id. (citing Bryant v. Joseph Tree, Inc., 119 Wn.2d 210, 220, 829 P.2d 1099 (1992)).

[29] Panag, 166 Wn.2d 27, 204 P.3d 885 (2009).

[30] Panag, 166 Wn.2d at 39.

> What is necessary, and does constitute the needed link between the plaintiff and the actor, is that the violation cause injury to the plaintiff's business or property as required by RCW 19.86.090. However, while RCW 19.86.090 requires such injury, and thus a connection between the wrongdoing (the wrongdoer) and the plaintiff, it does not require that the plaintiff be in a consumer or other business relationship with the actor. Under the plain language of the act, it is not necessary to establish any consumer relationship, direct or implied, between the parties.[31]

Safeco contends that the CPA claim is grounded in an alleged failure to pay what is owed the insured under the insurance contract and because Dr. Kerbs is not a party to that contract or an assignee of the insured he cannot establish any injury to his business or property. But this premise takes a narrow view of the scope of the CPA and ignores the economic realities of the interrelationships between Safeco, its insured and Dr. Kerbs. Notably, it was Safeco that directed Dr. Kerbs to submit his billings directly to Safeco and Safeco communicated with Dr. Kerbs that it was rejecting portions of his billings. Just because there is no contract between Safeco and Dr. Kerbs, there may still be a connection "in trade or commerce" between them. The economic reality is that if an insurer uses a bogus database in an unfair and deceptive manner to uniformly restrict payments for medical procedures to 85% of the database, without regard to any individual circumstances, and the insurer deals directly with medical providers in this process, then there arguably is a connection between the insured's acts and the business of the provider. The lack of a contract between the insurer and the medical provider and lack of an assignment by the insured does not mean the provider has not been actually injured in his or her business or property.

[31] Panag, 166 Wn.2d at 39–40 (footnote omitted).

Lack of Findings Supporting Award of Sanctions. Generally, a trial court must enter findings concerning the failure of counsel to meet the CR 11 standards.[32] "[I]n imposing CR 11 sanctions, it is incumbent upon the court to specify the sanctionable conduct in its order. The court must make a finding that either the claim is *not* grounded in fact or law and the attorney or party failed to make a reasonable inquiry into the law or facts, *or* the paper was filed for an improper purpose."[33] Formal findings may not be required if the trial court makes a record of the justifying reasons for imposing the CR 11 sanctions.[34] Similarly, an award of attorney fees requires that the court articulates its reasons supporting the award and makes "an adequate record so the appellate court can review [the] fee award."[35]

Here, there are no findings or record of the justifying reasons supporting the imposition of sanctions or the amount of the attorney fees. Dr. Kerbs argues that Safeco waived any such requirement by failing to request findings, but there is no authority for the proposition that the unsuccessful party must propose or request findings supporting the imposition of sanctions.

Nevertheless, the lack of necessary findings or adequate record does not compel a piecemeal appeal. The sanctions do not render further proceedings useless or

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[32] McNeil v. Powers, 123 Wn. App. 577, 590–91, 97 P.3d 760 (2004).

[33] Biggs, 124 Wn.2d at 201.

[34] Dexter v. Spokane County Health Dist., 76 Wn. App. 372, 377, 884 P.2d 1353 P.2d 1353 (1994) ("Although formal findings and conclusions are not required, a CR 11 award must be supported by justifying reasons.")

[35] Just Dirt, Inc. v. Knight Excavating, Inc., 138 Wn. App. 409, 415, 157 P.3d 431 (2007) (citing Mahler v. Szucs, 135 Wn.2d 398, 435, 957 P.2d 632 (1998).

substantially alter the status quo for purposes of RAP 2.3(b)(1 or (2). Safeco argues that the superior court's failure to provide a specific basis for the imposition of sanctions is a far departure from the accepted and course of proceedings. But RAP 2.3(b)(3) does not extend to a failure to offer specific reasons for a ruling. Otherwise it would gut the requirement that even an obvious error must render further proceedings useless to warrant discretionary review under RAP 2.3(b)(1). Rather, the far departure standard of RAP 2.3(b)(3) is limited to more extreme and unusual judicial conduct. The failure to indicate the specific reason for imposing sanctions does not warrant interlocutory review.

I note that if the court imposes contempt sanctions for failure to pay the award or if the trial court purports to recognize the award as a "final judgment" that may be collected upon, then those contempt sanctions, or the "final judgment" likely would be appealable as a matter of right.

Finally, the other arguments advanced by Safeco can be adequately addressed after a final judgment without incurring the delay or expense of a piecemeal appeal. Safeco does not satisfy the "stringent standards that apply to requests for interlocutory review."[36]

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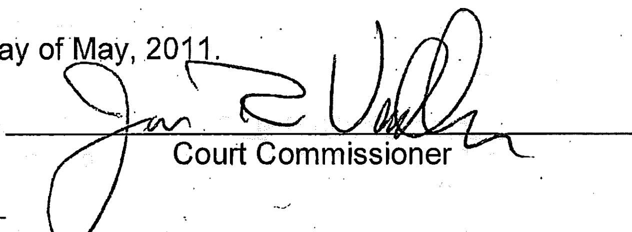
Now, therefore, it is hereby

ORDERED that discretionary review is denied.

Done this 16th day of May, 2011.



Court Commissioner

[36] Minehart II v. Morning Star Boys Ranch, Inc., 156 Wn. App. 457, 468, 232 P.3d 591 (2010)

BRESKIN JOHNSON & TOWNSEND PLLC

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