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Division I
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No. 72632-3-1

IN THE COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

CHRISTOPHER NELSON, a person,
REBECCA WIRTEL, a person,
and ALLI NELSON, a minor,

Plaintiffs/Appellants,

vs.

GEICO GENERAL INSURANCE COMPANY, an insurance
company,

Defendant/Respondent.

BRIEF OF AMICUS CURIAE
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

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On Behalf of
Washington State Association for Justice Foundation

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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to the Washington State Association for Justice (WSAJ). WSAJ Foundation has an interest in the rights of plaintiffs under the civil justice system, including an interest in interpretation and application of RCW 48.30.015, the key provision of the Insurance Fair Conduct Act (IFCA).

II. INTRODUCTION AND STATEMENT OF THE CASE

This appeal requires the Court to determine the viability of claims under the common law of insurance bad faith, the Consumer Protection Act, Ch. 19.86 RCW (CPA), and IFCA. This amicus curiae brief focuses on IFCA, and the interpretation and application of certain liability and damages provisions. This action was brought by Plaintiffs/Appellants Christopher Nelson, Rebecca Wirtel, and their minor daughter, Alli Nelson (collectively Nelsons) against their insurer, Geico General Insurance Company (Geico), for allegedly mishandling their uninsured/underinsured motorists insurance (UIM) claims.

The underlying facts are drawn from the briefing of the parties. See Nelsons Br. at 1-22; Geico Br. at 1-17; Nelsons Reply Br. at 1-2. For purposes of this brief, the following facts are relevant: Alli Nelson was

injured by an uninsured motorist on May 30, 2011, and her divorced parents, Christopher Nelson and Rebecca Wirtel, sought UIM benefits from Geico, which provided first-party automobile insurance for each parent under separate policies. On August 10, 2011, Geico was notified of the claim. There followed a protracted claims-handling process that the Nelsons found unsatisfactory. On October 10, 2013, Nelsons served Geico with a written notice of one or more violations of IFCA, pursuant to RCW 48.30.015(8). More than 20 days after this notice Nelsons filed suit against Geico, alleging wrongful conduct in adjusting the UIM claims. Nelsons sought recovery for breach of contract, common law insurance bad faith, unfair acts and practices under the CPA, and violation of IFCA. The superior court dismissed Nelsons' claims, including the claim brought under IFCA. See Geico Br. at 11.

Nelsons appealed to this court, and the issues on appeal include whether the superior court erred in dismissing the IFCA claim. Among other things, Nelsons argue that Geico's violations of one or more claims-handling regulations promulgated by the Insurance Commissioner, referenced in subsections (2), (3) and (5) of RCW 48.30.015, are actionable under the statute. See Nelsons Br. at 32-34; Nelsons Reply Br. at 13-19. Geico disagrees, urging that there was no denial of coverage or payment of benefits under the statute. See Geico Br. at 32-33.

III. ISSUES PRESENTED

- 1.) Is unreasonable delay by an insurer in handling a first-party insurance claim actionable under subsection (1) of RCW 48.30.015?
- 2.) Is violation of an Insurance Commissioner regulation referenced in subsections (2), (3) and (5) of RCW 48.30.015 actionable under the statute?
- 3.) Do “actual damages” recoverable under RCW 48.30.015(1) include emotional distress damages and, if so, what are the proof requirements for recovering these damages?¹

IV. SUMMARY OF ARGUMENT

Liability for Unreasonable Delay: An insurer’s unreasonable delay in determining coverage or paying benefits is implicit in the language prohibiting unreasonable denial of a claim for coverage or payment of benefits under subsection (1) of RCW 48.30.015, and should be actionable under this subsection of the statute. Any other interpretation undermines the intent and purposes of the act by allowing an insurer to unreasonably delay determinations regarding coverage or payment without

¹ See Nelsons Br. at 2, 34-36 (Issues 1 & 2); 37-38 (Issue 3); Geico Br. at 10-12, 17, 28 (Issue 3), 32-33 (Issue 1). None of the issues identified above have been considered by the Washington Supreme Court, despite the fact IFCA became law in 2007. In the meantime, federal district court cases have addressed IFCA and reached conflicting results without the benefit of guidance from the Washington appellate courts. See Langley v. Geico Gen. Ins. Co., — F. Supp. 3d —, 2015 WL 778619, at *2-3 (E.D. Wash., Feb. 24, 2015) (noting absence of Washington Supreme Court guidance regarding IFCA, and conflicting interpretations among federal district courts regarding the basis for liability under the statute). For this reason, certification of this appeal to the Washington Supreme Court would be justified. See RAP 4.4; see also RAP 4.2(2) (allowing for direct review by Supreme Court in cases “involving a fundamental and urgent issue of broad public import which requires prompt and ultimate determination”).

any consequences so long as it ultimately adjusts the claim correctly. If unreasonable delay results in actual damages, they are recoverable under subsection (1) and may be trebled under subsection (2) of RCW 48.30.015. Even when the delay does not cause actual damages, the insured may recover attorney fees and litigation costs under subsection (3) of the statute.

Violation of Insurance Commissioner Regulations: Reading the different provisions of IFCA together, including both RCW 48.30.010 and .015, in conjunction with the legislative intent underlying this act, violations of Insurance Commissioner regulations referenced in subsection (2), (3) and (5) of RCW 48.30.015 are separately actionable under this statute. There are different consequences for such misconduct, depending on whether the insured suffers actual damages as a result of the violation.

Scope of “Actual Damages”: An award of “actual damages” under RCW 48.30.015(1) may include proven emotional distress damages, and it should not be necessary to establish objective symptomology to recover these damages. Given that insurance is a matter of public interest, the insurer-insured relationship is quasi-fiduciary, and the insured’s security and peace of mind are among the principal benefits of first-party insurance, emotional distress damages are particularly foreseeable when a

claim for coverage or payment of benefits is unreasonably delayed or denied.

V. ARGUMENT

A.) **Overview of Remedies Available Against Insurers For Wrongful Conduct, Including Those Provided by IFCA.**

At the time IFCA was enacted in 2007, there was a fairly broad range of remedies available to insureds for wrongful conduct of an insurer.

These remedies, all of which remain available to this day, include:

Breach of Contract: The insurer-insured relationship arises from the insurance contract. Recovery for breach of contract is typically limited to amounts due under the contract plus interest. See Kirk v. Mt. Airy Ins. Co., 134 Wn. 2d 558, 560, 951 P.2d 1124 (1998). Generally, there is no recovery for general or punitive damages, or attorney fees and costs.

Equitable Attorney Fees: Given the disparity of bargaining power between insurer and insured, concern that litigation costs erode contracted-for benefits, and public policy that favors prompt payment of claims, a first-party insured who prevails in litigation with the insurer regarding a *coverage* issue is entitled to recover attorney fees and costs. See Olympic S.S. Co., Inc., v. Centennial Ins. Co., 117 Wn.2d 37, 52-53, 811 P.2d 673 (1991). This one-way fee shifting is not available if the dispute is over the

value of the claim. See Dayton v. Farmers Insurance Group, 124 Wn.2d 277, 280-81, 876 P.2d 896 (1994).

Common Law Tort Of Insurance Bad Faith: Independent of contract, insurer and insured have a duty to act in good faith, which is based upon public interest and the quasi-fiduciary nature of the insurer's relationship with its insured. See RCW 48.01.030 (declaring public interest and duty of good faith); Tank v. State Farm Fire & Cas. Co., 105 Wn.2d 381, 385-87, 715 P.2d 1133 (1986) (recognizing fiduciary nature of relationship). Liability for bad faith conduct sounds in tort, and may be based on negligence. See Am. Best Food, Inc. v. Alea London, Ltd., 168 Wn. 2d 398, 412, 229 P.3d 693 (2010) (recognizing that *unreasonable* conduct is actionable). Recovery for bad faith conduct may include "consequential damages" and "general tort damages." Coventry v. American States Ins. Co., 136 Wn.2d 269, 284-85, 961 P.2d 933 (1998); accord St. Paul Ins. Co. v. Onvia, Inc., 165 Wn.2d 122, 129-33, 196 P.3d 664 (2008).² This remedy does not include punitive damages, or attorney fees and costs.³

² Coventry, 136 Wn.2d at 284-85, equates "consequential damages" with damages incurred "as a result of the insurer's breach of its contractual and statutory obligations" and "amounts [the insured] has incurred as a result of the bad faith." Accord Onvia, 165 Wn.2d at 133. The Court of Appeals has interpreted "general tort damages" as including damages for mental or emotional distress. See American Manufacturers Mut. Ins. Co. v. Osborn, 104 Wn. App. 686, 698, 17 P.3d 1229 (citing Coventry), *review denied*, 144 Wn.2d 1005 (2001); Anderson v. State Farm Mut. Ins. Co., 101 Wn. App. 323, 333, 2 P.3d 1029 (2000) (citing Coventry), *review denied*, 142 Wn.2d 1017 (2001); Werlinger v.

CPA: Because the business of insurance implicates the public interest, an insured may also sue an insurer for violations of the CPA. See RCW 48.01.030 (declaring public interest in insurance); see also RCW 19.86.090 (enabling private CPA actions). Violations of the Insurance Code, Title 48 RCW, and certain Insurance Commissioner regulations, e.g. WAC 284-30-330, are deemed to be per se violations of the act. See Industrial Indem. Co. v. Kallevig, 114 Wn.2d 907, 920-25, 792 P.2d 520 (1990); Onvia, 165 Wn.2d at 133-34; Coventry, 136 Wn.2d at 276-81; see also RCW 19.86.170 (describing relationship between Insurance Code and its regulations and CPA).

Under the CPA, an insured may recover “actual damages” for *injury to business or property*, attorney fees and costs, and injunctive relief for an insurer's wrongful conduct. See RCW 19.86.090. Damages for mental and emotional distress are not recoverable under the CPA because they do not arise from injury to business or property. See

Clarendon Nat. Ins. Co., 129 Wn. App. 804, 809, 120 P.3d 593 (2005) (citing Anderson), *review denied*, 157 Wn.2d 1004 (2006); Miller v. Kenny, 180 Wn. App. 772, 802, 325 P.3d 278 (2014) (citing Anderson); but see Schmidt v. Coogan, 181 Wn. 2d 661, 666-77, 335 P.3d 424 (2014) (3-Justice lead opinion by Wiggins, J., noting that the availability of emotional distress damages for insurance bad faith has not been definitively addressed by the Supreme Court). Schmidt is discussed in §C, infra.

³ Under some circumstances a liability insurer may be liable in tort for damages awarded against its insured in excess of the policy limits. See Murray v. Aetna Cas. & Sur. Co., 61 Wn.2d 618, 620-21, 379 P.2d 731 (1963). Similarly, in cases involving a liability insurer's failure to defend, an insured (or assignee) may be awarded "coverage by estoppel" as a result of the insurer's wrongful conduct. See Truck Ins. Exch. v. Vanport Homes, Inc., 147 Wn. 2d 751, 764-66, 58 P.3d 276 (2002).

Washington State Physicians Ins. Exch. & Ass'n v. Fisons Corp., 122 Wn.2d 299, 317-18, 858 P.2d 1054 (1993). Under the CPA, the court has discretion to treble the actual damages amount, but only up to a maximum of \$25,000. See RCW 19.86.090.

IFCA: Notwithstanding the existence of the above remedies, in 2007 the Washington Legislature enacted IFCA, and the voters subsequently approved this enactment as Referendum Measure 67. See Laws of 2007, Ch. 498.⁴ The key features of IFCA are:

- Preliminarily, IFCA expressly preserves other remedies available at law involving conduct that is also actionable under IFCA. See RCW 48.30.015(6).
- Procedurally, IFCA requires a twenty-day pre-suit notice of claim before filing suit, providing an opportunity for the insurer “to resolve the basis for the action within the twenty-day period.” RCW 48.30.015(8).⁵

⁴ The full text of this legislation is reproduced in the Appendix to this brief, along with the Explanatory Statement for Referendum Measure 67, prepared by the Attorney General, and the statements for and against, prepared by the advocates for each side. The legislation amended RCW 48.30.010 and enacted RCW 48.30.015, and the latter statute references a number of regulations, WAC 284-30-330, -350, -360, -370 & -380. These statutes and regulations are also reproduced in the Appendix.

⁵ Geico describes subsection (8) of RCW 48.30.015 as creating a “notice and right to cure procedure,” suggesting that it provides insurers with a unilateral right to cure (and therefore avoid liability for) any IFCA violations. Geico Br. at 38. This is an extravagant view of what is a plain and unambiguous pre-suit notice of claim provision, designed to give the insurer fair warning and to encourage it to reach a *bilateral* resolution of the dispute within the time permitted, thereby avoiding litigation. Nowhere in subsection (8)

- IFCA creates a cause of action for unreasonable denial of a claim for coverage or the payment of benefits by a first-party insurer. See RCW 48.30.015(1). This supplements the tort of insurance bad faith and non-per se violations of the CPA, and is discussed in §B, infra.

- IFCA incorporates specified Insurance Commissioner regulations. See RCW 48.30.015(2)-(3) & (5). This appears to supplement per-se violations of the CPA, and the extent to which these regulations are actionable under IFCA is addressed in §B, infra.

- IFCA allows a first-party claimant to recover “actual damages” sustained as a result of the insurer’s violation of the act. See RCW 48.30.015(1)-(2). This supplements tort damages recoverable for insurance bad faith and damages for injury to business or property recoverable under the CPA. The meaning of the undefined statutory phrase “actual damages” is addressed in §C, infra.

- IFCA provides for recovery of expenses incurred by an insured who prevails in an IFCA action, including attorney fees, expert witness fees, and costs. See RCW 48.30.015(1) & (3). This supplements attorney fees and costs recoverable under Olympic S.S. and the CPA.

does the word “cure” or its equivalent appear. The language of this subsection is more akin to other notice of claim statutes, such as those in Chs. 4.92 and 4.96 RCW, than a provision for curing a deficient performance of a contractual obligation. Cf. RCW 62A.2-508(1) & Cmts. (regarding opportunity to cure non-conforming performance of contract for the sale of goods within the original time for performance).

- IFCA authorizes the court to “increase the total award of damages to an amount not to exceed three times the actual damages.” RCW 48.30.015(2). This eclipses treble damages available under the CPA, which are limited to damages arising from injury to business or property, and are subject to a \$25,000 maximum. IFCA’s relatively broad punitive damages provision is perhaps the centerpiece of the act, in that the prospect of punitive damages is a strong deterrent against wrongful conduct by an insurer.

B.) Unreasonable Delay By An Insurer In Handling A First-Party Insurance Claim Is Actionable Under RCW 48.30.015, As Are Violations Of The Insurance Commissioner Regulations Referenced In Subsections (2), (3) And (5) Of The Statute.

Nelsons contend that unreasonable delay in handling their UIM claims violates one or more Insurance Commissioner regulations referenced in RCW 48.30.015(5), and that such violations are actionable under subsections (2) and (3) of the statute. Nelsons do not directly address whether unreasonable delay in handling their UIM claims is actionable under subsection (1) of RCW 48.30.015.

In response, Geico does not appear to dispute that Insurance Commissioner regulations prohibit unreasonable delay in claims handling, but instead argues that “a WAC violation is not sufficient to constitute a violation of IFCA.” Geico Br. at 32-33. Geico further contends that

subsection (1) is limited to “unreasonable *denial* of a claim or benefit,” and does not encompass unreasonable delay. Id. (emphasis in original).

Whether IFCA prohibits unreasonable delay and whether violations of Insurance Commissioner regulations prohibiting such delay are actionable under the statute involves determining the voters’ intent in approving the act. See Roe v. TeleTech Customer Care Mgmt., 171 Wn. 2d 736, 746, 257 P.3d 586 (2011) (involving initiative). Intent is discerned primarily from the text of the enactment. See Roe, 171 Wn. 2d at 746-47. To the extent there is any ambiguity in the text, it is appropriate to consider information in the voters’ pamphlet. See id.; Belas v. Kiga, 135 Wn. 2d 913, 934, 959 P.2d 1037 (1998) (considering information in voters pamphlet to interpret referendum).

When the text of IFCA is read in conjunction with the voters’ pamphlet, it is apparent subsection (1) of RCW 48.30.015 should be interpreted to prohibit unreasonable delay in claims handling as a form of unreasonable denial of a claim for coverage or payment of benefits. Furthermore, violations of regulations referenced in subsections (2), (3) and (5) of the statute that prohibit unreasonable delay in claims handling are also actionable in their own right under the statute.

1.) Accountability For Unreasonable Delay Is Implicit In The Prohibition Of Unreasonable Denial Of A Claim

**For Coverage Or Payment Of Benefits Under
Subsection (1) of RCW 48.30.015.**

Subsection (1) of RCW 48.30.015 provides:

Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

Unreasonable delay in handling a claim is tantamount to a denial of a claim for coverage or payment of benefits, and should be deemed to violate this subsection of RCW 48.15.030, independent of any violation of Insurance Commissioner regulations referenced in the statute.

If an insurer could delay a determination of coverage or payment of benefits unreasonably without any liability, so long as it ultimately adjudicated the claim correctly, this would undermine the express obligations contained in subsection (1). Such an interpretation would be contrary to the public policy favoring prompt payment of insurance claims. See Olympic S.S., 117 Wn. 2d at 53; Messinger v. New York Life Ins. Co., 20 Wn. App. 790, 793-94 & n.3, 581 P.2d 1381 (1978) (indicating interest limitation clause might be contrary to public policy favoring prompt payment of insurance claims). It would also deprive the insured of the “security and peace of mind [that] are principal benefits of insurance.” National Surety Corp. v. Immunex Corp., 176 Wn. 2d 872,

878, 297 P.3d 688 (2013) (involving third-party context; brackets added); accord Coventry, 136 Wn.2d at 283 (first-party context).

Recognizing unreasonable delay as a violation of subsection (1) of RCW 48.15.030 is consistent with the voters' intent in approving IFCA. The act was submitted to voters as Referendum Measure 67. The statement in favor of the referendum measure in the voter's pamphlet emphasizes that IFCA will deter and provide a remedy for delay, in addition to denial of valid insurance claims. The statement in favor contains eight separate references to delay and payment of claims in a timely manner. See Appendix. The rebuttal statement and statement against the measure do not contradict or take issue with this description of IFCA. See id. In light of the voters' pamphlet, interpreting IFCA as not prohibiting unreasonable delay in claims handling would frustrate the expectations of the voters who approved the referendum.⁶

2.) The Prohibition Of Unreasonable Delay Is Explicit In Insurance Commissioner Regulations Referenced In Subsections (2), (3) and (5), And, When The Statute Is Read As A Whole, Violation Of These Regulations Is Actionable.

Subsections (2) and (3) of RCW 48.30.015 provide:

⁶ The word "delay" was stricken from a proposed Senate amendment to IFCA See S.S.B. 5726 S. Amd. To S. Amd. 254, 60th Legis., Reg. Sess., Mar. 13, 2007. It is unclear why the legislators rejected this proposal. Moreover, such legislative history should not be relevant to interpreting a referendum approved by the voters, especially when the voters' pamphlet manifests an intent to address unreasonable delay by insurers in processing claims.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

Subsection (5) references a number of regulations adopted by the Insurance Commissioner, including those requiring prompt claims handling. See e.g. WAC 284-30-330(6).

Subsections (2), (3) and (5) all presume that violations of the referenced Insurance Commissioner regulations are actionable, even though the regulations are not expressly mentioned as a basis for an award of actual damages in subsection (1). These subsections should be read together. The regulations are identified as a basis for an award of treble damages in subsection (2) and attorney fees and litigation costs in subsection (3). The disjunctive “or” used in subsections (2) and (3) indicates that violations of the regulations are alternative and independent means of establishing liability under the statute. If the regulations were not

intended to be independently actionable, there would have been no reason to include them in the text of the statute.⁷

This interpretation is supported by IFCA's addition of subsection (7) to RCW 48.30.010. As part of the same enactment, the two statutes should be read together. See City of Seattle v. Allison, 148 Wn. 2d 75, 81, 59 P.3d 85, 88 (2002). Subsections (1)-(6) of RCW 4.30.010 prohibit unfair or deceptive acts or practices in the insurance industry, and authorize the Insurance Commissioner to adopt and enforce regulations defining such unfair or deceptive acts or practices. IFCA added subsection (7) to RCW 48.30.010, which mirrors subsection (1) of RCW 48.30.015, and provides in pertinent part that “[a]n insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant.” (Brackets added.) The addition of subsection (7) indicates equivalence between unreasonable denial of a claim for coverage or payment of benefits and violation of Insurance Commissioner regulations, because both constitute unfair or deceptive acts or practices prohibited by the Insurance Code. See RCW 48.30.010(1)-(2)

⁷ An alternative path to this interpretation is represented by the federal district court's opinion in Langley, *supra*, 2015 WL 778619, at *4-5, which recognizes an implied cause of action under RCW 48.30.015 for violation of the regulations identified in subsection (5) of the statute. This implied cause of action analysis seems to be a reaction to other federal district court decisions concluding that violations of the regulations alone are not actionable. See id. at *2-3; see also Hann v. Metropolitan Cas. Ins. Co., 2012 WL 3098711, at *2 (W.D. Wash., July 30, 2012) (collecting contrary cases).

(providing WAC violations are unfair or deceptive acts or practices in addition to violations of Insurance Code itself). At the same time, the addition indicates a distinction between unreasonable denial of a claim for coverage or payment of benefits and violation of the regulations, because they are separately stated. See RCW 48.30.010(1)-(2); RCW 48.30.015(1)-(3).

Recognizing an independent action for violations of the regulations under RCW 48.30.015 reflects both the equivalence and the distinction between unreasonable denial of a claim for coverage or payment of benefits and violation of the regulations. This results in a symmetry of remedies for the Insurance Commissioner under RCW 48.30.010 and private litigants under RCW 48.30.015. Both can bring an action for *either* unreasonable denial of a claim for coverage or payment of benefits *or* violation of the regulations (or both).

This interpretation is supported by the legislative history of IFCA.

The official ballot title states:

This bill would make it unlawful for insurers to unreasonably deny certain coverage claims, and permit treble damages plus attorney fees for that *and other violations*.

Appendix (emphasis added). The Explanatory Statement describes the pre-IFCA state of the law as allowing the Insurance Commissioner to take

action against insurers in violation of its regulations, and explains that the effect of IFCA would be to

authorize any first party claimant to bring a lawsuit in superior court against an insurer for unreasonably denying a claim for coverage or payment of benefits, *or violation of specified insurance commissioner unfair claims handling practices regulations*, to recover damages and reasonable attorney fees, and litigation costs.

Id. (emphasis added). The statements for and against Referendum Measure 67 do not take issue with these descriptions of IFCA. In light of these statements in the voters' pamphlet, interpreting IFCA to preclude actions for violations of Insurance Commissioner regulations referenced therein would frustrate the expectations of the voters who approved the referendum.

C.) Under RCW 48.30.015(1) "Actual Damages" Should Include Damages For Emotional Distress, And The Insured Should Not Be Required To Prove Objective Symptomology In Order To Recover.

It does not appear from the parties' briefing that the superior court's dismissal of the IFCA claim was based in part on the grounds that "actual damages" under RCW 48.30.015(3) do not include general damages for emotional distress. See Geico Br. at 10-12. However, the parties discuss

this issue on appeal, so it is addressed here. See Nelsons Br. at 37-38; Geico Br. at 28.⁸

The undefined phrase “actual damages” in RCW 48.30.015(1) refers to the full complement of tort damages, including general damages for emotional distress, based on the ordinary meaning of the phrase. See Rasor v. Retail Credit, 87 Wn.2d 516, 522-31, 554 P.2d 1041 (1976) (interpreting “actual damages” in federal Fair Credit Reporting Act (FCRA) remedy provision, 15 U.S.C. § 1681o, to mean “all the elements of compensatory awards generally,” specifically including mental anguish and suffering); Martini v. Boeing, 137 Wn.2d 357, 366-68, 971 P.2d 45 (1999) (interpreting “actual damages” in Washington Law Against Discrimination (WLAD) remedy provision, RCW 49.60.030(2), to mean “full compensatory damages, excluding only nominal, exemplary or punitive damages,” following Rasor).⁹

⁸ In 2013, the Washington Supreme Court accepted a certification from the United States District Court, Western District of Washington that involved the meaning of “actual damages” under IFCA, but the case settled before argument. See Morella v. Safeco Ins. Co. (S.C. #88706-3). WSAJ Foundation filed an amicus curiae brief in Morella. There is currently pending before the Supreme Court another case involving the definition of “actual damages” in RCW 59.18.085, providing a remedy for certain displaced tenants, and whether the phrase includes damages for emotional distress. See Segura v. Cabrera, 179 Wn.App. 630, 319 P.3d 98 (2-1 split opinion), *review granted*, 181 Wn.2d 1006 (2014). WSAJ Foundation filed an amicus curiae brief in Segura as well.

⁹ These holdings are not based upon application of rules of liberal construction. See Rasor, 87 Wn.2d at 529-30 (acknowledging remedial nature of FCRA, but interpreting “actual damages” based upon “generally accepted legal meaning”); Martini, 137 Wn.2d at 364 (acknowledging WLAD rule of liberal construction, but holding “actual damages” is unambiguous and applying definition from *Black’s Law Dictionary*); see also Segura, 179 Wn.App. at 643-51 (Fearing, J., dissenting, reviewing authorities and concluding that

In enacting IFCA's "actual damages" provision, the Legislature is deemed to be mindful of this Court's interpretation of similar statutory provisions.¹⁰ Consequently, the Legislature's choice to use the undefined phrase "actual damages," without qualification, should be read as reflecting an intent to permit recovery for emotional distress under RCW 48.30.015(1).

This result is consistent with the recent decision in Schmidt v. Coogan, 181 Wn.2d 661, 335 P.3d 424 (2014), where the Supreme Court determined that emotional distress damages were not recoverable under the particular facts of a legal malpractice case. The Court held:

the plaintiff in a legal malpractice case may recover emotional distress damages when significant emotional distress is foreseeable from the sensitive or personal nature of representation or when the attorney's conduct is particularly egregious. However, simple malpractice resulting in pecuniary loss that causes emotional upset does not support emotional distress damages.

181 Wn.2d at 671 (3-justice lead opinion by Wiggins, J.); accord id. at 674.¹¹ Coogan is distinguishable because the Court was not interpreting the statutory phrase "actual damages." Nonetheless, interpreting the

"actual damages" in RCW 59.18.085(3) includes emotional distress damages). The CPA interprets the phrase "actual damages" in RCW 19.86.020 differently because of the additional "injury to business or property" requirement of that act. See supra §A.

¹⁰ Cf. City of Federal Way v. Koenig, 167 Wn. 2d 341, 348, 217 P.3d 1172 (2009) (stating the "court presumes that the legislature is aware of judicial interpretations of its enactments").

¹¹ The 4-justice concurrence by Justice Fairhurst states that "under the facts of this case emotional distress damages are not available," but does not otherwise expressly endorse the reasoning of the lead opinion on this issue. 181 Wn.2d at 680, n.6 (Fairhurst, J., concurring).

phrase as it appears in RCW 48.30.015(1) to include emotional distress damages is in keeping with Coogan, which allows these damages “when significant emotional distress is foreseeable from the sensitive or personal nature of representation.” See 181 Wn.2d at 671 (Wiggins, J., lead opinion) Emotional distress is foreseeable in the insurance context because of the quasi-fiduciary relationship between insurer and insured, and the fact that the insured obtains coverage for the “security and peace of mind [that] are the principle benefits of insurance.” National Surety, 176 Wn. 2d at 878 (brackets added).

Emotional distress damages recoverable as “actual damages” under RCW 48.30.015(1) should not be subject to a proof requirement of “objective symptomatology.” In Bylsma v. Burger King Corp., 176 Wn.2d 555, 562, 293 P.3d 1168 (2013), a product liability case, the Supreme Court held that, in the absence of physical impact, emotional distress damages are generally recoverable only “if the emotional distress is a reasonable response and manifested by objective symptomatology.” As with Coogan, Bylsma is distinguishable because the Court was not interpreting the statutory phrase “actual damages.” The Court’s freedom to impose limits on the common law damages recovery incorporated into the Washington Product Liability Act does not apply to issues of statutory construction. See 176 Wn. 2d at 566 (indicating Washington Product

Liability Act incorporates common law rules regarding damages). As a result, Bylsma is not controlling here.

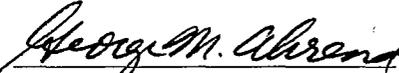
In any event, in adopting the objective symptomatology requirement in Bylsma, the Court distinguished a line of contrary cases permitting recovery for emotional distress—absent physical injury and without any additional proof of objective symptomatology—because these cases “concerned emotionally laden personal interests, and emotional distress was an expected result of the objectionable conduct in each case.” Bylsma at 561. This line of cases should control here. Emotional distress is an expected result when there is an unreasonable denial of a claim for coverage or payment of benefits or violation of Insurance Commissioner regulations. Such wrongful conduct may well shatter the security and peace of mind that insurance is supposed to provide.

VI. CONCLUSION

The Court should adopt the analysis of IFCA set forth in this brief, and apply this analysis in resolving the IFCA issues on appeal.

DATED this 17th day of August, 2015.


For BRYAN P. HARNETIAUX
WSBA # 5169
WITH AUTHORITY


GEORGE M. AHREND
WSBA # 25160

On Behalf of WSAJ Foundation

CERTIFICATE OF SERVICE

I certify: By prior arrangement, counsel for the parties have agreed to electronic service of this proposed amicus curiae brief and accompanying motion at the email addresses stated below.

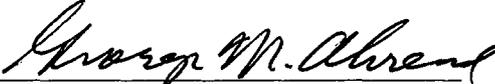
I have arranged to have copies of this proposed amicus curiae brief with accompanying motion served this date on the counsel listed below at the following email addresses:

Joel Hanson, on behalf of Plaintiffs/Appellants
joel@joelhansonlaw.com

Alfred E. Donohue, on behalf of Defendant/Respondent
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Stew Estes, on behalf of Washington Defense Trial Lawyers
sestes@kbmlawyers.com

Signed at Ephrata, Washington on this 17th day of August, 2015.


GEORGE M. AHREND

Appendix

2007 Wash. Legis. Serv. Ch. 498 (S.S.B. 5726) (WEST)

WASHINGTON 2007 LEGISLATIVE SERVICE
60th Legislature, 2007 Regular Session

Additions are indicated by ~~Text~~; deletions by
~~Text~~ . Changes in tables are made but not highlighted.
Vetoed provisions within tabular material are not displayed.

CHAPTER 498
S.S.B. No. 5726

INSURANCE—BOARDS AND COMMISSIONS—RULES AND REGULATIONS

AN ACT Relating to creating the insurance fair conduct act; amending RCW 48.30.010; adding a new section to chapter 48.30 RCW; creating a new section; and prescribing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. This act may be known and cited as the insurance fair conduct act.

Sec. 2. RCW 48.30.010 and 1997 c 409 s 107 are each amended to read as follows:

<< WA ST 48.30.010 >>

(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, 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 after a review of all comments received during the notice and comment rule-making period.

(3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

(b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

(c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

~~(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in section 3 of this act.~~

NEW SECTION. Sec. 3. A new section is added to chapter 48.30 RCW to read as follows:

<< WA ST 48.30 >>

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

- (a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";
- (b) WAC 284-30-350, captioned "misrepresentation of policy provisions";
- (c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";
- (d) WAC 284-30-370, captioned "standards for prompt investigation of claims";
- (e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or
- (f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

Approved May 15, 2007.

Effective July 22, 2007.

WA LEGIS 498 (2007)



REFERENDUM MEASURE 67

Passed by the Legislature and Ordered Referred by Petition

Official Ballot Title:

The legislature passed Engrossed Substitute Senate Bill 5726 (ESSB 5726) concerning insurance fair conduct related to claims for coverage or benefits and voters have filed a sufficient referendum petition on this bill.

This bill would make it unlawful for insurers to unreasonably deny certain coverage claims, and permit treble damages plus attorney fees for that and other violations. Some health insurance carriers would be exempt.

Should this bill be:

Approved | | Rejected | |

Votes cast by the 2007 Legislature on final passage:

Senate: Yeas, 31; Nays, 18; Absent, 0; Excused, 0.
House: Yeas, 59; Nays, 38; Absent, 0; Excused, 1.

Note: The Official Ballot Title was written by the court. The Explanatory Statement was written by the Attorney General as required by law and revised by the court. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth fiscal analysis, visit www.ofm.wa.gov/initiatives. The complete text of Referendum Measure 67 begins on page 29.

Fiscal Impact Statement

Fiscal Impact Statement for Referendum 67

Referendum 67 is a referendum on ESSB 5726, a bill that would prohibit insurers from unreasonably denying certain insurance claims, permitting recovery up to triple damages plus attorney fees and litigation costs. This may increase frequency and amounts of insurance claims recovered by state and local government, the number of insurance-related suits filed in state courts, and increase state and local government insurance-premiums. Research offers no clear guidance for estimating the magnitude of these potential increases. Notice of insurance-related suits must be provided to the Office of the Insurance Commissioner prior to court filing, costing an estimated \$50,000 per year.

Assumptions for Fiscal Analysis of R-67

- There would likely be an increase in the number of cases filed in Superior Court related to the denial of insurance claims, but there is no data available to provide an accurate estimate of that fiscal impact. It is assumed that the impact to the operations of Washington courts would be greater than \$50,000 per year.
- Premiums for state and local governments that purchase auto, property, liability or other insurance may increase due to a potential increase in insurance companies' litigation costs and the amounts awarded to claimants.
- When the state or local government is a claimant, the referendum could increase the likelihood of recovering on the claim, and the amount recovered.
- Various studies have been conducted to determine how changes in law affecting insurance can affect costs for courts, insurance premiums, and claimant recovery. However, individual study results vary widely. Due to the conflicting research, there is no clear guidance for estimating the magnitude of the fiscal impact of potential increases in court costs, insurance premiums, or recovered claims.
- It is estimated that 300 notices per year of insurance-related lawsuits would be filed with the Office of the Insurance Commissioner, resulting in a minimum cost of less than \$50,000 per year increased cost to the agency.





REFERENDUM MEASURE 67

Explanatory Statement

The law as it presently exists:

The state insurance code prohibits any person engaged in the insurance business from engaging in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of their business. Some of these practices are set forth in state statute. The insurance commissioner has the authority to adopt rules defining unfair practices beyond those specified in statute. The commissioner has the authority to order any violators to cease and desist from their unfair practices, and to take action under the insurance code against violators for violation of statutes and regulations. Depending on the facts, the insurance commissioner could impose fines, seek injunctive relief, or take action to revoke an insurer's authority to conduct insurance business in this state.

Under existing law, an unfair denial of a claim against an insurance policy could give the claimant a legal action against the insurance company under one or more of several legal theories. These could include violation of the insurance code, violation of the consumer protection laws, personal injuries or property losses caused by the insurer's acts, or breach of contract. Depending on the facts and the legal basis for recovery, a claimant could recover money damages for the losses shown to have been caused by the defendant's behavior. Additional remedies might be available, depending on the legal basis for the claim.

Plaintiffs in Washington are not generally entitled to recover their attorney fees or litigation costs (except for small amounts set by state law) unless there is a specific statute, a contract provision, or recognized ground in case law providing for such recovery. Disputes over insurance coverage have been recognized in case law as permitting awards of attorney fees and costs. Likewise, plaintiffs in Washington are not generally entitled to collect punitive damages or damages in excess of their actual loss (such as double or triple the amount of actual loss), unless a statute or contract specifically provides for such payment.

The effect of the proposed measure, if approved:

This measure is a referral to the people of a bill (ESSB 5726) passed by the 2007 session of the legislature. The term "this bill" refers here to the bill as passed by the legislature. **A vote to "approve" this bill is a vote to approve ESSB 5726 as passed by the legislature. A vote to "reject" this bill is a vote to reject ESSB 5726 as passed by the legislature.**

ESSB 5726 would amend the laws concerning unfair or deceptive insurance practices by providing that an insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any "first party claimant." The term "first party claimant" is defined in the bill to mean an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

ESSB 5726 would authorize any first party claimant to bring a lawsuit in superior court against an insurer for unreasonably denying a claim for coverage or payment of benefits, or violation of specified insurance commissioner unfair claims handling practices regulations, to recover damages and reasonable attorney fees, and litigation costs. A successful plaintiff could recover the actual damages sustained, together with reasonable attorney fees and litigation costs as determined by the court. The court could also increase the total award of damages to an amount not exceeding three times the actual damages, if the court finds that an insurer has acted unreasonably in denying a claim or has violated certain rules adopted by the insurance commissioner. The new law would not limit a court's existing ability to provide other remedies available at law. The claimant would be required to give written notice to the insurer and to the insurance commissioner's office at least twenty days before filing the lawsuit.

ESSB 5726 would not apply to a health plan offered by a health carrier as defined in the insurance code. The term "health carrier" includes a disability insurer, a health care service contractor, or a health maintenance organization as those terms are defined in the insurance code. The term "health plan" means any policy, contract, or agreement offered by a health carrier to provide or pay for health care services, with certain exceptions set forth in the insurance code. These exceptions include, among other things, certain supplemental coverage, disability income, workers' compensation coverage, "accident only" coverage, "dental only" and "vision only" coverage, and plans which have a short-term limited purpose or duration. Because these types of coverage fall outside the definition of "health plan," ESSB 5726's provision would apply to these exceptions to "health plans."



Statement For Referendum Measure 67

APPROVE 67 – MAKE THE INSURANCE INDUSTRY TREAT ALL CONSUMERS FAIRLY.

Referendum 67 simply requires the Insurance Industry to be fair and pay legitimate claims in a reasonable and timely manner. Without R-67, there is no penalty when insurers delay or deny valid claims. R-67 would help make the Insurance Industry honor its commitments by making it against the law to unreasonably delay or deny legitimate claims.

APPROVE 67 – RIGHT NOW, THERE IS NO PENALTY FOR DELAYING OR DENYING YOUR VALID CLAIM.

R-67 encourages the Insurance Industry to treat legitimate insurance claims fairly. R-67 allows the court to assess penalties if an insurance company illegally delays or denies payment of a legitimate claim.

APPROVE 67 – YOU PAY FOR INSURANCE. THEY SHOULD KEEP THEIR PROMISES.

When you pay your premiums on time, the Insurance Industry is supposed to pay your legitimate claims. Unfortunately, the Insurance Industry sometimes puts profits ahead of people and intentionally delays or denies valid claims. R-67 makes the Insurance Industry keep its promises and pay legitimate claims on time. That is why the Insurance Industry is spending millions of dollars to defeat it.

APPROVE 67 – JOIN BIPARTISAN OFFICIALS AND CONSUMER GROUPS SUPPORTING FAIR TREATMENT BY THE INSURANCE INDUSTRY.

Insurance Commissioner Mike Kriedler, former Insurance Commissioners, seniors, workers, and consumer groups urge you to approve R-67. Supporters include the Puget Sound Alliance of Senior Citizens, former Republican Party State Chair Dale Foreman, the Labor Council, and the Fraternal Order of Police.

APPROVE 67 – R-67 SIMPLY MAKES SURE CLAIMS ARE HANDLED FAIRLY.

If the Insurance Industry honors its commitments, R-67 does not impose any new requirements – other than making sure all claims are handled fairly. R-67 would have an impact only on those bad apples that unreasonably delay or deny valid insurance claims.

For more information, visit www.approve67.org.

Rebuttal of Statement Against

Washington is one of only 5 states with no penalty when the Insurance Industry intentionally denies a valid claim. That is why the Insurance Industry is spending millions to defeat R67. Referendum 67 is only on the ballot because the Insurance Industry used its special-interest influence to block it from becoming law. Now you can vote to *approve* R67 to make fair treatment by the Insurance Industry the law. Approve R67 for Insurance Fairness.

Voices: Pamphlet Argument Prepared by:

STEVE KIRBY, Chair, House Insurance, Financial Services, Consumer Protection Committee; TOM CAMPBELL, Chair, House Environmental Health Committee; DIANE SOSNE, RN, President, SEIU 199; SKIP DREPS, Government Relations Director, Northwest Paralyzed Veterans; KELLY FOX, President, Washington State Council of Firefighters; STEVE DZIELAK, Director, Alliance for Retired Americans.

Statement Against Referendum Measure 67

REJECT FRIVOLOUS LAWSUITS. REJECT HIGHER INSURANCE RATES. REJECT R-67.

As if there weren't enough frivolous lawsuits jacking up insurance rates, Washington's trial lawyers have invented yet another way to file more lawsuits to fatten their pocketbooks. They wrote and pushed a law through the Legislature that permits trial lawyers to threaten insurance companies with *triple damages* to force unreasonable settlements that will *increase insurance rates for all consumers*. The trial lawyers also included a provision that *guarantees payment of attorneys' fees*, sweetening the incentive to file frivolous lawsuits. There's no limit on the fees they can charge. What does this mean for consumers? You guessed it: *higher insurance rates*.

TRIAL LAWYERS WIN. CONSUMERS LOSE.

R-67 is a *windfall for trial lawyers* at the expense of consumers. Trial lawyers backed a similar law in California, but the resulting explosion of fraudulent claims and frivolous lawsuits caused auto insurance prices to increase 48% more than the national average (according to a national actuarial study) and *it was later repealed*.

CURRENT LAW PROTECTS CONSUMERS.

Insurance companies have a legal responsibility to treat people fairly, and *consumers can sue insurance companies under current law* if they believe their claim was handled improperly. The Insurance Commissioner can—and does—levy stiff fines, or even ban an insurance company from the state, if the company mistreats consumers.

R-67 IS BAD NEWS FOR CONSUMERS. REJECT R-67.

Not only does R-67 raise auto and homeowners insurance rates, it applies to small businesses and doctors as well. That means *higher medical bills and higher prices* for goods and services.

Laws should reduce frivolous lawsuits, not create more. Reject R-67!

See for yourself. Visit www.REJECT67.org.

Rebuttal of Statement For

Don't be fooled.

Trial lawyers didn't push this law through the legislature to protect *your* rights. They want this law because it gives them new opportunities to file *frivolous lawsuits* and collect *fat lawyers' fees*.

Trial lawyers don't care if frivolous lawsuits jack up our insurance rates. *Consumers, doctors and small businesses will pay more* so trial lawyers can file more lawsuits and collect larger fees.

Reject frivolous lawsuits and excessive lawyers' fees. Reject 67.

Voices: Pamphlet Argument Prepared by:

W. HUGH MALONEY, M.D., President, Washington State Medical Association; DON BRUNELL, President, Association of Washington Business; RICHARD BIGGS, President, Professional Insurance Agents of Washington; DANA CHILDERS, Executive Director, Liability Reform Coalition; TROY NICHOLS, Washington State Director, National Federation of Independent Business; BILL GARRITY, President, Washington Construction Industry Council.

West's Revised Code of Washington Annotated
Title 48. Insurance (Refs & Annos)
Chapter 48.30. Unfair Practices and Frauds (Refs & Annos)

West's RCWA 48.30.010

48.30.010. Unfair practices in general--Remedies and penalties

Effective: December 6, 2007

Currentness

(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, 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 after a review of all comments received during the notice and comment rule-making period.

(3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

(b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

(c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in RCW 48.30.015.

Credits

[2007 c 498 § 2 (Referendum Measure No. 67, approved November 6, 2007); 1997 c 409 § 107; 1985 c 264 § 13; 1973 1st ex.s. c 152 § 6; 1965 ex.s. c 70 § 24; 1947 c 79 § .30.01; Rem. Supp. 1947 § 45.30.01.]

Notes of Decisions (70)

West's RCWA 48.30.010, WA ST 48.30.010

Current with all laws from the 2015 Regular and First Special Sessions that are effective on or before July 24, 2015; the general effective date for laws from the Regular Session, and available laws from the 2015 Second and Third Special Sessions

End of Document

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West's Revised Code of Washington Annotated
Title 48. Insurance (Refs & Annos)
Chapter 48.30: Unfair Practices and Frauds (Refs & Annos)

West's RCWA 48.30.015

48.30.015. Unreasonable denial of a claim for coverage or payment of benefits

Effective: December 6, 2007

Currentness

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";

(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";

(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";

(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";

(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

Credits

[2007 c 498 § 3 (Referendum Measure No. 67, approved November 6, 2007).]

Notes of Decisions (33)

West's RCWA 48.30.015, WA ST 48.30.015

Current with all laws from the 2015 Regular and First Special Sessions that are effective on or before July 24, 2015, the general effective date for laws from the Regular Session, and available laws from the 2015 Second and Third Special Sessions

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

WAC 284-30-330

284-30-330. Specific unfair claims settlement practices defined

Currentness

The following are hereby 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:

- (1) Misrepresenting pertinent facts or insurance policy provisions.
- (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- (3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
- (4) Refusing to pay claims without conducting a reasonable investigation.
- (5) Failing to affirm or deny coverage of claims within a reasonable time after fully completed proof of loss documentation has been submitted.
- (6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.
- (7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.
- (8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring a first party claimant or his or her physician to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

Credits

Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-330, filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.

Current with amendments adopted through the 15-14 Washington State Register dated, July 15, 2015.

WAC 284-30-330, WA ADC 284-30-330

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Washington Administrative Code
Title 284. Insurance Commissioner, Office of
Chapter 284-30. Trade Practices (Refs & Annos)
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WAC 284-30-350

284-30-350. Misrepresentation of Policy Provisions

Currentness

(1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No insurance producer or title insurance agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

Credits

Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). 11-01-159 (Matter No. R 2010-09), § 284-30-350, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-350, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.

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WAC 284-30-360

284-30-360. Standards for the insurer to acknowledge pertinent communications.

Currentness

(1) Within ten working days after receiving notification of a claim under an individual insurance policy, or within fifteen working days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification given to an agent of the insurer is notification to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within fifteen working days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ten working days for individual insurance policies, or fifteen working days with respect to communications arising under group insurance contracts.

(4) Upon receiving notification of a claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section constitutes compliance with that subsection.

Credits

Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200 and RCW 48.30.010, 48.44.050, and 48.46.200. 13-12-079 (Matter No. R 2013-05), § 284-30-360, filed 6/5/13, effective 1/1/14. Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-360, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-360, filed 7/27/78, effective 9/1/78.

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WAC 284-30-370

284-30-370. Standards for prompt investigation of a claim

Currentness

Every insurer must complete its investigation of a claim within thirty days after notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

Credits

Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-370, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.

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WAC 284-30-370, WA ADC 284-30-370

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WAC 284-30-380

284-30-380. Settlement standards applicable to all insurers

Currentness

(1) Within fifteen working days after receipt by the insurer of fully completed and executed proofs of loss, the insurer must notify the first party claimant whether the claim has been accepted or denied. The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the specific provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer must contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other means than in writing, an appropriate notation must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it must notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If after that time the investigation remains incomplete, the insurer must notify the first party claimant in writing stating the reason or reasons additional time is needed for investigation. This notification must be sent within forty-five days after the date of the initial notification and, if needed, additional notice must be provided every thirty days after that date explaining why the claim remains unresolved.

(4) Insurers must not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers must not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. This notice must be given to first party claimants thirty days and to third party claimants sixty days before the date on which any time limit may expire.

(6) The insurer must not make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a specified period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(7) Insurers are responsible for the accuracy of evaluations to determine actual cash value.

Credits

Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No: R 2008-07), § 284-30-380, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-380, filed 7/27/78, effective 9/1/78.

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