

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

---

ROBERT W. FERGUSON  
Attorney General

MARTA DELEON, WSBA #35779  
Assistant Attorney General  
PO Box 40100  
Olympia, WA 98504-0100  
(360) 586-0812  
Marta.deleon@atg.wa.gov

ORIGINAL

filed via  
PORTAL

## TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	IDENTITY AND INTEREST OF AMICUS .....	2
III.	SCOPE OF AMICUS BRIEF .....	2
IV.	ISSUES.....	3
V.	FACTS RELEVANT TO AMICUS.....	3
VI.	ARGUMENT .....	8
	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. ....	10
	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. ....	12
VII.	CONCLUSION .....	14

## TABLE OF AUTHORITIES

### Cases

<i>Credit Gen. Ins. Co. v. Zewdu</i> , 82 Wn. App. 620, 919 P.2d 93 (1996).....	9
<i>Inland Empire Distrib. Sys., Inc. v. Utils. &amp; Transp. Comm'n</i> , 112 Wn.2d 278, 770 P.2d 624 (1989).....	9
<i>King Cy. v. Central Puget Sound Growth Mgmt. Hearings Bd.</i> , 42 Wn.2d 543, 14 P.3d 133 (2000).....	8
<i>Port of Seattle v. Pollution Control Hearings Bd.</i> , 151 Wn.2d 568, 90 P.3d 659 (2004).....	9
<i>PUD 1 of Pend Oreille Cy. v. Dep't of Ecology</i> , 146 Wn.2d 778, 51 P.3d 744 (2002).....	8

### Statutes

Laws of 1993, ch. 242, §§ 2, 4.....	3, 4
RCW 34.05.325(6)(a) .....	4
RCW 48.22.005(7).....	1, 4, 13
RCW 48.22.095(1)(a) .....	4, 13
RCW 48.30.010(2).....	3
RCW 48.37.010 .....	7
RCW 48.37.080 .....	7
WAC 284-30-300.....	3
WAC 284-30-310.....	3
WAC 284-30-395 (1).....	5, 11

## 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.<sup>1</sup>

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

---

<sup>1</sup> 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<sup>2</sup>; *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.<sup>3</sup>

///

---

<sup>2</sup> 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).

<sup>3</sup> 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 assess 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).

///

///

**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

///

///

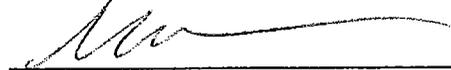
///

///

to provide for those purchasing PIP coverage.

RESPECTFULLY SUBMITTED this 25th day of January, 2018.

ROBERT W. FERGUSON  
Attorney General



---

MARTA DELEON, WSBA #35779  
Assistant Attorney General  
Attorneys for Respondent

## **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.

**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 misled.*

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

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

*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

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

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.*

Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6

"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.*

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

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*

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

*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

Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6

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 abandoned. 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 specialties 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

Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6

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<sup>1</sup> 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 speciality. An IME in the same speciality 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

---

<sup>1</sup> " (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.

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

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 specialties 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*

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

*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*

Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6

*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 health carrier will not make

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6**

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

Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses  
R 96-6

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

**Attachment A to Concise Explanatory Statement --  
Summary of Comments on PIP Rule and Responses.  
R 96-6**

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%<sup>1</sup> 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.<sup>2</sup>

### **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

---

<sup>1</sup>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).

<sup>2</sup>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% 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.

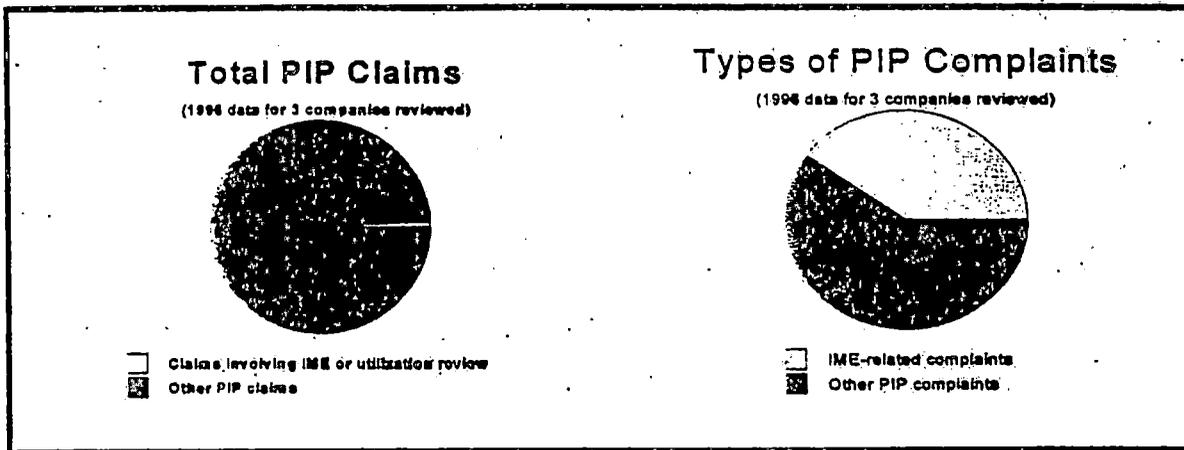
More detailed data collected from three of the largest insurers in the market appears to support conclusions regarding potential misunderstandings that take place when companies exercise some form of medical utilization review of PIP claims. The 1996 company data shows that although Independent Medical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

---

<sup>3</sup>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<sup>4</sup>. (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 to 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<sup>5</sup>). 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<sup>6</sup>) are reviewed by insurers using independent exams.

---

<sup>4</sup>This provision was not adopted.

<sup>5</sup>This conclusion is based on interviews, a survey, and comments received from insurers.

<sup>6</sup>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<sup>7</sup>), 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

---

<sup>7</sup> 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<sup>8</sup> estimates that fraud adds 10% to the cost of the average property and casualty insurance policy. A study by the RAND Institute<sup>9</sup> 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.<sup>10</sup> In general, it appears that fraud, most commonly seen in the form of excessive medical charges, adds significantly to the cost of PIP claims.

---

<sup>8</sup>Page 1 of September 9, 1996 edition.

<sup>9</sup>A. Carroll, A. Abrahamse, M. Vaiana, The Costs of Excess Medical Claims for Automobile Personal Injuries, RAND Institute, 1995.

<sup>10</sup>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<sup>11</sup>. 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.

---

<sup>11</sup>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 Kappahn, 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**

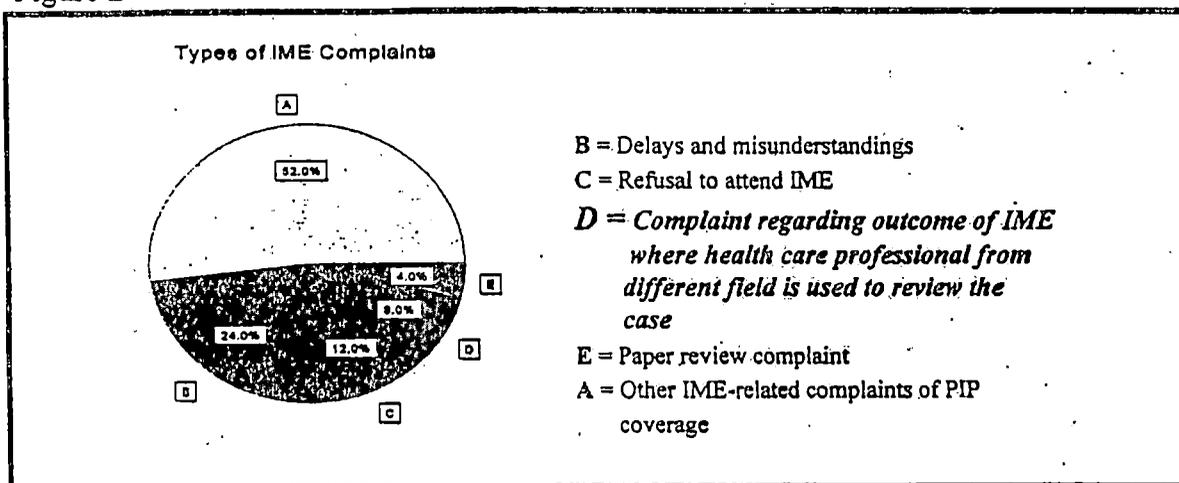
To assess the potential benefits of the requirement that reviewing health care professionals be in the same health care license as the treating professional, I use OIC complaint data. The Insurance Commissioner most likely does not receive all of the complaints insured persons may have regarding their 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<sup>2</sup>.

---

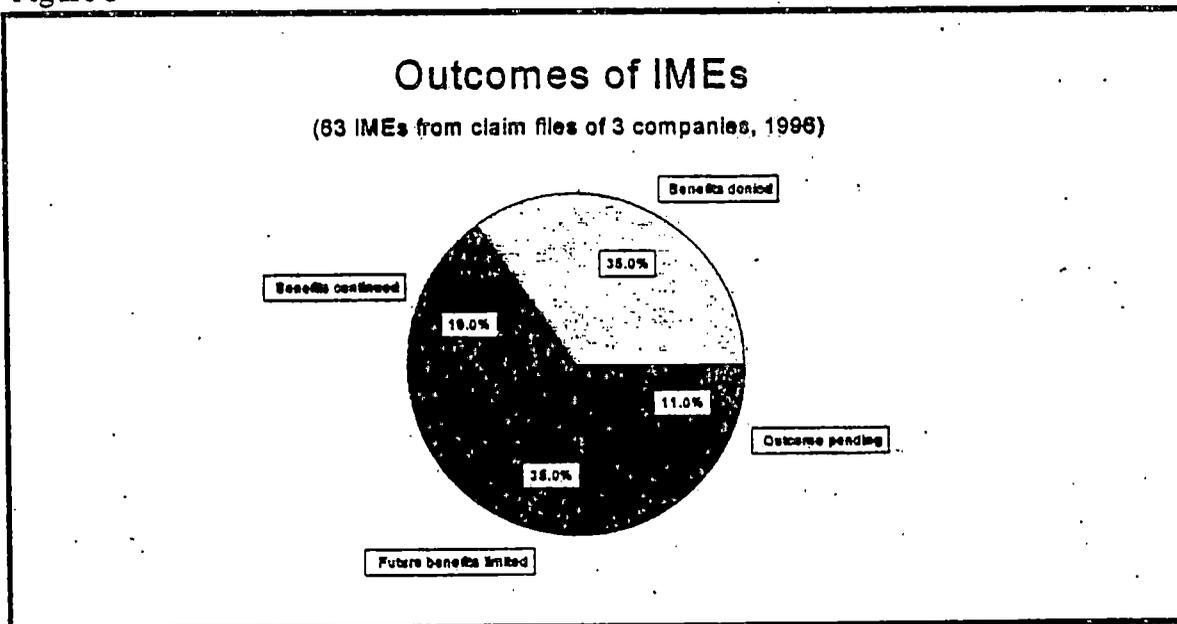
<sup>2</sup>It is possible that more than two of these cases involved IME professionals in fields different from the treating professional. If this issue was not specifically addressed in the complaint summary, it was not included.

Figure 2



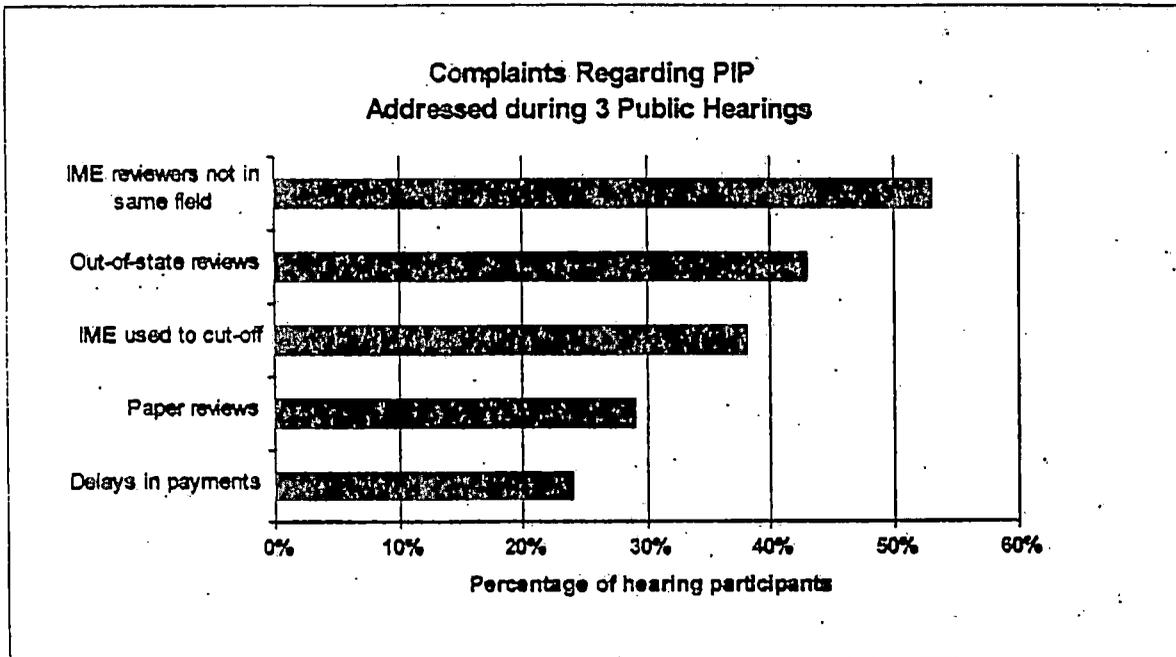
Results from data compilations collected from three of the major auto insurers in the state are also in line with OIC database estimations. The data show that of the 3 insurers observed, claim reimbursements are stopped after an IME in approximately 35% of the cases, claim reimbursements are limited 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<sup>13</sup>. In three OIC Public Hearings held in Seattle, Spokane and Everett<sup>14</sup>, 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

<sup>13</sup>Calculated from 177 complaints filed with three of the largest auto-insurers in the market in 1996.

<sup>14</sup>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

<u>Preliminary Drafts</u>		<u>Rule as Adopted</u>
<b>General Disclosure</b>		
<p>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.</p>		<p>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.</p>
<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>The cost would be over \$1.00 per claim.</li> </ul>	<p>Cost Reduction →→→→</p>	<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>For an estimated<sup>1</sup> 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.</li> </ul>
<b>Peer Review Disclosure</b>		
<p>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.</p>		<p>Because of the difficulties specified by insurers, this rule was modified such that no questionnaire (to be completed by health care professionals) is required.</p>
<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>Difficulties would exist in forcing health care professionals to complete this type of questionnaire.</li> </ul>	<p>Cost Reduction →→→→</p>	<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>Insurers will not be required to complete a provider questionnaire. Potential cost impacts are reduced to zero.</li> </ul>
<b>Peer Reviews</b>		
<p>Previous drafts included requirements that reviewing health care professionals be licensed in the state of Washington.</p>		<p>The rule no longer requires that these health care professionals be licensed exclusively in the state of Washington.</p>
<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Cost Reduction →→→→</p>	<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>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 costs are eliminated.</li> </ul>

<sup>1</sup> 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.
<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>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).</li> </ul>	<p>Cost Reduction →→→→</p>	<p><b>Cost estimated by Insurers:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>
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.
<p><b>Cost estimated by Insurers:</b></p> <p>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.</p>	<p>Cost Reduction →→→→</p>	<p><b>Cost estimated by Insurers:</b></p> <p>This has been eliminated, reducing the cost of compliance to zero.</p>

**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.

EAWPDOCSVIPAUTOVMELEMNT.PIP  
June 4, 1997

---

Rule-Making Implementation Plan  
PIP -- R 96-6

**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<sup>1</sup>. 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<sup>2</sup>. 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

<sup>1</sup> This conclusion is based on interviews, a survey, and comments solicited from the insurers.

<sup>2</sup> This conclusion is based on interviews, a survey, and comments solicited from the insurers.

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:

<b>Preliminary Drafts</b>		<b>Draft proposal upon filing of CR-102</b>
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 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.

<sup>3</sup> estimation based on a phone survey, sampling 10% of the insurers affected by proposed rule

- (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 12<sup>th</sup> through October 17<sup>th</sup>, 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.

(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.

**SUPREME COURT OF THE STATE OF WASHINGTON**

BRENT DURANT, on behalf of himself  
and all others similarly situated,

Plaintiffs,

v.

STATE FARM MUTUAL  
AUTOMOBILE INSURANCE  
COMPANY,

Defendant.

DECLARATION OF  
SERVICE

I, Julie Feser, make the following declaration:

1. I am over the age of 18, a resident of Pierce County, and not a party to the above action.

2. On February 15, 2018, I caused to be served a true and correct courtesy copy of the Corrected Amicus Curiae Brief and this Certificate of Service via U.S. Mail to:

VAN SICLEN STOCKS & FIRKINS  
Tyler K. Firkins  
David Hauheim  
721 45<sup>th</sup> Street NE  
Auburn, WA 98002

SHEPPARD MULLIN RICHTER &  
HAMPTON LLP  
Frank Falzetta  
Jennifer M. Hoffman  
333 South Hope Street, 43rd Floor  
Los Angeles, California 90071-1448

LEWIS BRISBOIS LLP  
Gregory S. Worden  
1111 Third Ave., Suite 2700  
Seattle, Washington 98101

RESPECTFULLY SUBMITTED this 15th day of February, 2018.

  
\_\_\_\_\_  
JULIE FESER, Legal Assistant

AGO/GCE

February 15, 2018 - 3:37 PM

Transmittal Information

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

**The following documents have been uploaded:**

- 947716\_Briefs\_20180215153540SC222390\_7989.pdf  
This File Contains:  
Briefs - Amicus Curiae  
*The Original File Name was Corrected-20180215-CLEANAmicusBrief.pdf*

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

- jhoffman@sheppardmullin.com
- Gregory.Worden@lewisbrisbois.com
- Tom@ThomasAdkins-law.com
- bonitaf@richter-wimberley.com
- colette.saunders@lewisbrisbois.com
- danhuntington@richter-wimberley.com
- davidnauheim@gmail.com
- ddworsky@sheppardmullin.com
- diana@vansiclen.com
- ffalzetta@sheppardmullin.com
- laura.young@lewisbrisbois.com
- tfirkins@vansiclen.com
- valeriemcomie@gmail.com
- vicki.milbrad@lewisbrisbois.com

**Comments:**

Corrected Amicus Curiae Brief

---

Sender Name: Julie Feser - Email: Julief1@atg.wa.gov

**Filing on Behalf of:** Marta Uballe Deleon - Email: martad@atg.wa.gov (Alternate Email: Julie.Feser@atg.wa.gov)

Address:

PO Box 40100  
1125 Washington Street SE  
Olympia, WA, 98504-0100  
Phone: (360) 664-9006

**Note: The Filing Id is 20180215153540SC222390**

PCL XL error

Warning: IllegalMediaSize